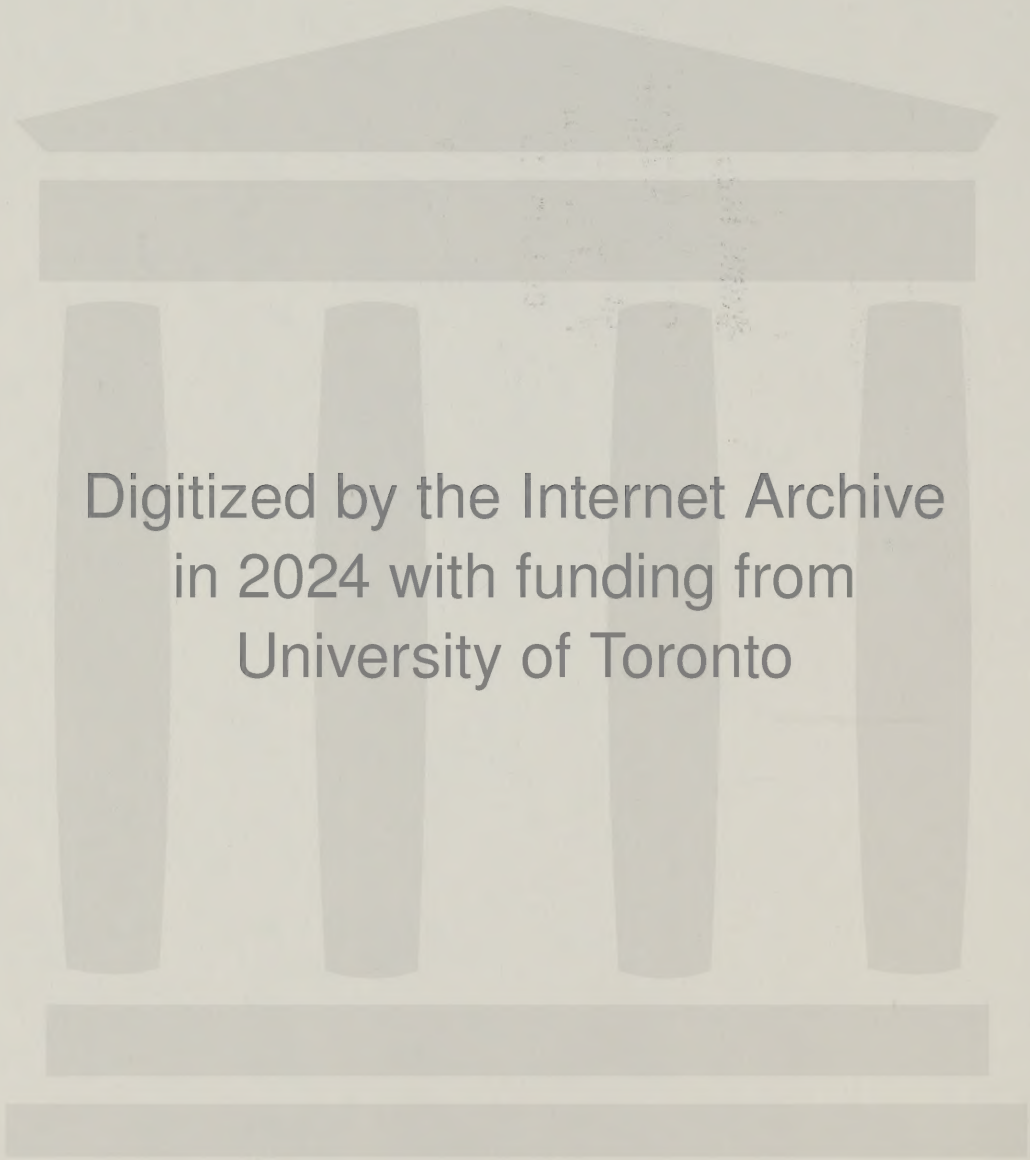

Ontario [Commissions and committees of inquiry] Committee on the Healing Arts

Study.

[No. 7] Social work in Ontario.

1970

ONTARIO

SOCIAL WORK IN ONTARIO

Michael Landauer

A Study for the
Committee on the Healing Arts

1970

FOREWORD

The Committee on the Healing Arts was established by the Province of Ontario, Order in Council 3038/66, dated July 14, 1966.

During the summer of 1968, the Committee requested an internal research study on social work in Ontario. Michael Landauer of the Committee staff undertook this study and the Committee believes that the information in this study would be of interest to many persons associated with this area of health services.

The statements and opinions contained in this study are those of Mr. Landauer, and publication of this study does not necessarily mean that all such statements and opinions are endoresed by the Committee.

I.R.Dowie, Chairman
M.C. Urquhart
Horace Krever

PREFACE

The Committee on the Healing Arts distributed two questionnaires in the summer of 1967 - one to the Administrators of Social Work Agencies and Departments in the Province of Ontario and a second to a sample of social workers drawn from the active Ontario membership in the Canadian Association of Social Workers. Much of the data and analysis in the Report is based on returns to these questionnaires. The rate of returns to the Administrators questionnaires was 83 per cent and to the sample of members of the CASW, 59 per cent.

M.L.

ACKNOWLEDGEMENT

The author wishes to acknowledge his debt to Miss Florence Philpott, Executive Director of the Canadian Association of Social Workers, for her assistance in securing the active cooperation of the Association in the surveys. Miss May Harman of the Ontario Association of Professional Social Workers was also very helpful.

Without the willing and expert assistance of Mr. Jack Amos, Miss Florence Knoll, Dr. Rita Lindenfield, Mrs. Margaret Reid and Miss Shirley Stinson, all leaders in their respective fields of social work, we could not hav e prepared the questionnaires. Any deficiencies are the sole responsibility of the author.

Dr. John Smiley of the Department of Health helped in the technical aspects of sample and questionnaire design.

Mrs. Jenny Wong worked closely on the project during most of its phases and her advice continually was sound.

Finally I wish to acknowledge the seriousness and enthusiasm with which administrators and caseworkers in every field of social work responded to the questionnaires. I hope that this report presents enough interesting information to repay them.

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Chapter 1

INTRODUCTION

Social Work Defined

A recruitment flyer written for the University of Toronto School of Social Work by its director, Professor Charles Hendry, states:

> Social work as a profession is both multiple and mobile; but its basic elements are always the same: help, encouragement, adaptation and change - disciplined intervention.[1]

A 1965 report prepared by the United States Department of Health, Education and Welfare on social work, manpower and education defines social work as follows:

> The term "social work" as used in this report describes the system of organized activities carried on by a person with particular knowledge, competence and values, designed to help individuals, groups, or communities towards a mutual adjustment between themselves and their social environment. The goal of social work is the enhancement or restoration of the capacity for social functioning of individuals or groups or the development of community conditions that support social welfare through counselling; the provision of services,

1. Charles Hendry, Social Work Needs People Who Care, University of Toronto School of Social Work, 1965, p. 2.

or community organization activities.[2]

The Reverend Swithun Bowers, O.M.I., an eminent Canadian social work educator, has also formulated a widely-used definition of social work:

> ...social work is a professional activity in which knowledge about the interaction of man and his environment and skill in helping relationships with people are used to enable people to attain a greater adequacy in their social functioning.[3]

The standing of social work as a profession is a question of great importance to the graduates of social work schools. It is an issue to which we will return shortly.

The Development of Social Work

A recruiting pamphlet published by the Central Youth Employment Executive in the Ministry of Labour of the British Government reviews the historical background of social work:

> The aim of all social workers is to help people live fuller, happier and more worthwhile lives. There have been men and women in every century who have devoted themselves to doing this and to aiding the helpless and the downtrodden. These social workers were largely inspired by religious motives. This was particularly so in the Middle Ages when the relief of the poor and the succoring of the aged and the sick were a feature of the work of the monasteries and the abbeys.
> With the dissolution of the monasteries in the 16th Century, the work of relief and rescue fell increasingly to laymen with well developed social consciences.

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2 Departmental Task Force on Social Work Education and Manpower, Closing the Gap in Social Manpower, U.S. Department of Health, Education and Welfare, Washington, D.C., 1965, p. 4.

3 Swithun Bowers, O.M.I., quoted in Canadian Association of Social Workers, Proposed Policy Statement on Professional Competence in Social Work Practice, 1967, mimeo, p. 3. Father Bowers is Vice-Rector, St. Patricks College, University of Ottawa.

> ...in the 18th Century the break-up of village life, rapid industrialization of Britain and the haphazard growth of factories and crowded towns caused problems so vast that they could not be dealt with by individual charity or by such measures as the Poor Law Act of 1601.[4]

Throughout the nineteenth century many enlightened and sympathetic persons devoted their lives to creating organizations for the alleviation of the widespread distress or to persuading parliament to introduce legislation to improve the degrading conditions. Elizabeth Fry, John Pounds, Robert Owen, Florence Nightingale and William Booth were among the luminaries. Scores of volunteers followed them into the prisons, the slums and the battlefields, dedicating themselves to the work of saving body and soul.

In the twentieth century "the extension of democratic ideals to the social and economic arena" through programs of welfare assistance and social security has institutionalized the provision of social services and been a major source of a growing demand for social work personnel. It is only in this century that social work has become the province of full-time, paid personnel rather than volunteers.

In the last few years, intensified campaigns against Want, Disease, Ignorance, Squalor and Idleness - Lord Beveridge's "five giants in the way of social progress" - have created additional personnel

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4 Central Youth Employment Executive, Social Workers, 3rd ed., Her Majesty's Press, London, 1965, pp. 4-5.

demands in the programs introduced to obtain the goals of social progress.

During recent years, there has been great alarm at an emerging pattern of dependency transmitted from generation to generation. Evidence has accumulated that a self-perpetuating culture of poverty is being produced. This is so antithetical to the hopes of those who introduced programs of public assistance that the premises and programs of public welfare and social security are now under broad review. The occupation of social work has been accused of perpetuating problems of poverty to assure its own continuation and to satisfy base psychological drives. But a larger and more influential body of opinion maintains that what has really been lacking in the public welfare programs are more intensive personal services, designed to motivate and train people trapped in conditions of poverty to become confident, skilled and self-supporting. Thus in both the United States and Canada several items of legislation in recent years have called for an increased volume of skilled counselling and other personal services as part of various social welfare programs.

Underlying these legislative acts is the belief that the helping and healing professions possess sufficient knowledge and skills to make a considerable impact on the problems of dependency and family conflict.

In addition to the demands for social workers implied in the trends above, an increasing emphasis on prevention and rehabilitation in many areas of social welfare, such as child protection, juvenile and adult crime, alcoholism and drug addiction, has been accompanied by increased attention to emotional problems of individuals and families and greater demand for skilled counselling services. In the field of health care, too, several strong trends are at work to increase the demand for personel to provide a full range of social work services. We shall discuss these trends at greater length below.

The cumulative effect of these developments on the demand for social work personnel trained at every level of skill has engendered the "crisis in social work manpower". The crisis, to recapitulate, has been caused by commitments to new and enlarged programs in many areas of the health, education and welfare fields, that require social work skills, often at an advanced level. Seventy to 80 per cent of those presently employed as social workers in Ontario have no academic training in social work. The three graduate schools of social work in the province do not have the resources to educate social workers in the numbers or to the range of levels of skill required to implement programs already planned.

The attitude of leading educators and public officials in Ontario towards the social work manpower situation is illustrated in a report by the Presidents' Research Committee to the Committee of Presidents of Universities of Ontario:

> A shortage of social workers has been a chronic condition in Canada and elsewhere for some time. What brings it into particularly sharp focus at the present is the very great volume of recent and current social legislation requiring trained personnel for its implementation. There are not enough people now to staff the existing welfare services. On top of this, Medicare will add to the numbers of paramedical staff required and the Canada Assistance Act will require large numbers of skilled staff to implement it; policies being developed in the Department of Reform Institutions and under the Poverty and Opportunity Program will add to the staffing problem.
>
> We recommend a major thrust by the universities of Ontario, individually and collectively, to meet the critical needs in the welfare field - that they investigate the possibilities mentioned above, that they give leadership and assistance in the development of appropriate related programs in the colleges of applied arts and technology, and that the existing professional schools give a high priority to the expansion of the specialized aspects, such as medical social work and psychiatric social work. Clearly, the crisis in the welfare field constitutes a need of society to which the universities must respond.[5]

At a later point in the report we will discuss shortages of social workers in the medical and psychiatric settings in particular.

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5 Presidents' Research Committee, From the Sixties to the Seventies: An Appraisal of Higher Education in Ontario, Committee of Presidents of Universities of Ontario, Toronto, 1967, pp. 88-89.

Contending with the "Crisis"

Several councils, conferences and committees have considered the problems of meeting the demand for social work personnel in Ontario. They have made many important decisions during the three or four years they have been in operation. The two most important committees in Ontario focusing attention on preparation for the social services are the Minister's Advisory Council on Public Welfare Training in the Department of Social and Family Services, which has been meeting since February 9, 1961, and the Continuing Conference on Education and Training for the Social Services in Ontario, which has been meeting since the middle of 1967.

The first committee is composed of a small group of senior executives in government departments and in schools of social work. The Minister's Advisory Council has considered and commented on the problem of defining levels and categories of responsibility in social work and of designing appropriate training courses for the various levels. It was actively involved in consultation with the Minister of Education and representatives of his Department in the establishment of a two-year welfare services course, which was inaugurated at the Ryerson Polytechnical Institute in September 1964, and which opened up the question of vocational training for the social services.

The Minister's Advisory Council has also been active in negotiating with universities in Ontario for the establishment of new undergraduate programs in the social services and for the expansion of existing graduate programs and the establishment of new graduate schools.

The second committee dealing with the manpower crisis on a continuing basis, the Continuing Conference on Education and Training for the Social Services in Ontario, comprises a larger group. It is composed of representatives from the various institutions preparing personnel for the social services, public officials from the Ontario government departments that employ social work personnel, other major employers and the Association of Professional Social Workers.

The Continuing Conference has recently established three standing committees on manpower requirements, problems of field instruction and problems related to the differential use of staff with varying levels of training. It has been suggested that the Continuing Conference may evolve from the status of a discussion group into a formal organization and employ permanent staff to support and undertake research in these areas.

In 1965 only the University of Toronto, Carleton University and Waterloo Lutheran University had formal programs in social work.

They were all graduate schools offering the Master of Social Work degree after a two-year curriculum, including both course and field work. By 1970, a new graduate school of social work will be established, five universities will have undergraduate degree programs in social work, and nine colleges of applied arts and technology will be educating social workers at the technical and vocational level.

According to a projection by the Director of Staff Training and Development for the Department of Social and Family Services, there will be 1,451 field placements utilized in 1971-1972, compared with 338 field placements utilized in the province of Ontario in 1966-1967. This is an indication that the number of social workers being educated in the various streams in 1971-1972 will be more than four times the number being trained in 1966-1967.

The quantitative picture is quite impressive; the response to the crisis in social work manpower has been direct and strong. Qualitatively, however, the adequacy of the response remains to be evaluated. Before we return to a more specific consideration of recent developments in the education and training of social workers we shall turn to the problems of identifying social work as a profession and the elements of professional competence in social work.

Social Work as a Profession

According to Harold J. Wilensky, a profession is characterized at a minimum by "a recognized claim on the part of the members to technical competence in a field of activity". A profession is usually based on a structure of scientific theory.

In 1915, Abraham Flexner asked "Is Social Work a Profession?"

H.J. Meyer writes that

> ...the knowledge base for social work has hardly been identified... The large literature on practice has not yet provided a clear description of the technical competence that social workers possess... The weight given to an existing or sought for scientific basis for practice varies among social workers.[6]

Mrs. Helen Harris Perlman, professor of social work at the School of Social Service Administration in the University of Chicago, challenges social workers in these terms:

> All three social work methods - casework, group work and community organization thus have as their major task ahead the development of their practice theory, the theory that explains and guides their action. What the social worker does and how he does it - this is what will spell the special identity of the social work profession.
>
> We are surely and even rapidly adding to our store of knowledge. We have given tongue and heart to what we believe in and hold to be good, but the "what" and

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6 Henry J. Meyer, "Professionalization and Social Work" in Alfred J. Kahn, ed., Issues in American Social Work, Columbia University Press, New York, 1959, p. 326 ff.

"how" of carrying knowledge and belief into action - these are yet to be formulated. And this is difficult.[7]

Dr. Alfred J. Kahn, Chairman of the Commission on Social Work Practice of the National Association of Social Workers, warned that "the lack of methodical, progressive accretion of knowledge on which to base practice is the Achilles' heel of the profession."[8]

It is only within the last half-century that the practice of social work or helping others in trouble has become a full-time occupation for large numbers of people. Until 1916, the annual conference of social workers in the United States was known as the Conference of Charities and Corrections.

In 1917 Mary Richmond published Social Diagnosis,[9] in which she recommends a systematic, objective approach to individual cases and the casting of the worker-client relationship into the medical model of diagnosis, prescription and treatment. At about the same time, although independently of Miss Richmond's efforts, the methods of analytical psychiatry were winning their way into an important place in the curriculum of the new schools of social work that had been recently established. Modern social casework thinking dates from the publication of Miss Richmond's work and is still heavily

7 Helen Harris Perlman, "Social Work Method: A Review of the Past Decade", in National Association of Social Workers, Trends in Social Work Practice and Knowledge, New York, 1966.

8 Alfred J. Kahn, "The Nature of Social Work Knowledge" in Cora Kasius, ed., New Directions in Social Work, Harper and Brothers, New York, 1954, pp. 210-211.

9 Mary Richmond, Social Diagnosis, Russell Sage Foundation, New York, 1917.

influenced by the doctrines of analytical psychiatry.

In the years since 1917, casework - a type of relationship therapy - has become by far the most popular method in social work. Until very recently, at least, almost 90 per cent of the graduates of schools of social work have majored in that method rather than in group work or community organization.

What is casework and how is it distinguished from psychoanalysis and psychotherapy? A bulletin of the Community Service Society of New York (a family service agency) defines casework as

> ...a method of study and treatment used by a professionally trained social worker with a Master's degree in social work to help an individual with problems of daily living. The caseworker enables the client to use his own intellectual and emotional capacities constructively in overcoming his problems ... While the caseworker must know the extent to which behaviour is influenced by inner and outer forces, he confines himself to exploring and handling the client's environment, his conscious thinking, feeling and acting, and thoughts and feelings that can be easily recalled.[10]

An act passed by the California Senate on July 20, 1967, attempts to clarify the limits of the role that social workers with the Master of Social Work degree can perform. The Act defines a "clinical social worker". Section 9049 of the Act states:

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10 Community Service Society of New York, Bulletin, September 1964, p. 1.

> The practice of clinical social work is defined as a service in which a special knowledge of social resources, human capabilities, and the part that unconscious motivation plays in determining behaviour, is directed at helping people to achieve more adequate, satisfying and productive social adjustments. The application of social work principles and methods includes, but is not restricted to, counselling and using applied psychotherapy of a non-medical nature with individuals, families and groups; providing or arranging for the provision of social services; explaining or interpreting the psycho-social aspects in the situations of individuals, families and groups; helping communities to organize to provide or improve social and health services; and doing research related to social work.[11]

It is clear that despite the profound and widely felt confusion about the knowledge base of social work practice, graduate social workers have succeeded in having social work defined and accepted as a profession.

Some attempts have been made to define professional competence in social work. At the most general level, Werner Boehm, Dean of the Graduate School of Social Work at Rutgers State University in New Brunswick, New Jersey, states that "The focus on social relationships comprising the interaction between the individual and environment is the distinguishing characteristic of the field of social work."

At a less general level, Harriet M. Bartlett, a leading medical social worker and head of the medical social work project completed

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11 Amendment to Business & Professions Code, Second Extraordinary Session of the California Legislature, 1966, Ch. 17.

in 1940, concluded that despite an embryonic framework of concepts, it is possible to "discern an orderliness and consistency in the way in which social workers approach clients, analyse problems which are presented and offer services directed towards meeting those problems".[12]

Most recently, Dr. Rita Lindenfield, consultant in social work to the Clarke Institute in Toronto and a member of the University of Toronto faculties, both in the School of Social Work and the Department of Psychiatry, has attempted to define in more specific terms the body of knowledge and the set of skills that comprise professional competence in social work practice. Included by Dr. Lindenfield in the body of knowledge are

1) An understanding of the client's dynamics, as these are revealed in social functioning.

2) An understanding of the factors in the client's environment and the impact of these on social functioning.

3) An understanding of the nature of help: what is involved on the part of the client and the helper; what promotes and what impedes help.

4) An understanding of the nature of professional relationships as the primary vehicle of help.

5) An understanding of the various techniques and levels of communication and their place in the helping process.

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12 Harriett M. Bartlett, Social Casework in a Medical Setting, American Association of Medical Social Workers, Chicago, 1940, p. 2.

6) An understanding of the functions and the structures of the network of services in the community and the degree to which such services are meeting the needs of the clientele.[13]

Among the skills included by Dr. Lindenfield is the ability on the part of the worker to:

1) Offer service in such a way that the client is encouraged and/or helped to use it appropriately.

2) Secure information selectively on the basis of the client's needs and the service presented.

3) Establish a productive relationship which is differentiated on the basis of the needs of the client.

4) Promote and use an interaction which enables a client to move ahead and find a way to cope with his problems more effectively.

5) Assess in an on-going manner the client's needs, his capacities to meet these and the resources available in his environment.

6) Help the client identify his problems, his own and other resources for dealing with these.

7) Help the client set realistic goals with due regard to the limits inherent in any person and/or situation.

8) Recognize when other than social work is indicated and help the client avail himself of such help.

9) Know when and how to terminate if the client no longer needs the service and/or no longer is profiting from the service.

10) Help design and/or use an appropriate administrative structure for the tasks to be performed.

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13 Rita Lindenfield, in Canadian Association of Social Workers, "Proposed Policy Statement on Professional Competence in Social Work Practice", mimeo, 1967, pp. 2-5.

It must be noted that while Dr. Lindenfield's definition of professional competence includes a specification of the kinds of knowledge necessary for professional practice, there is no indication as to how fundamental and how precise is the stock of human knowledge in these areas.

Mr. John W. Gardner, former president of the Carnegie Corporation and former Secretary of Health, Education, and Welfare in the United States, speculated on the future of social work as a profession in 1966. He wrote that by 1990

> ...among these professional schools, the school of social work will be one of the most important. We cannot be sure that it will be called a <u>school of social work</u> nor can we describe the curriculum, but it will be a legitimate lineal descendant of the present schools.
>
> Like all the great professional schools of 1990, it will have extremely close ties with the basic fields of science and scholarship in the university - in this case with the behavioural and social sciences. Indeed it will not be ranked as a distinguished school of social work unless it is associated with an institution in which those fields are strong....another feature of the school of social work in the 1990's is that it will have made itself a hospitable home for all of the great array of occupations - professional, sub-professional and technical - that make up the field of social welfare broadly conceived.... Sometime in the late 1960's the profession decided that it was self-defeating to build walls between itself and its natural allies....[14]

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14 <u>op. cit.</u>, quoted in Departmental Task Force, p. 63.

Some Special Problems in Education and Training

In recent years there has been some reaction within the social work profession against the exaggerated concentration on the casework method among M.S.W. students and in favour of encouraging emphasis on the methods of community organization and social research. Social work educators have recognized and been discouraged by the lack of important participation by graduate social workers in the design of public policies for the welfare state. As well, social work in all of these methods has been severely hampered by a very weak tradition in schools of social work of sophisticated and productive research into the underlying causes and methods of alleviating social pathologies. Social planning at the institutional level and casework at the individual level both depend on building a knowledge base for their future development.

Social work educators are in the process of a major reconsideration of the goals and methods at every level of social work education. At the graduate level, a fundamental restructuring of the program is under active consideration. One concept suggests a greater concentration on training social work students for specialized roles such as caseworker, researcher and administrator. This

approach is consistent with the observation of Oswald Hall on a paper delivered by John Morgan in Ottawa recently:

> Professor Morgan does not clearly define what a social worker is, will be, or should be. Hence it is extremely difficult for the Universities to know how to train people for this ill-defined occupation... A large part of the difficulty seems to arise from the fact that social work is currently evolving into several distinct occupations, each massive enough to occupy the full lifetime of a person.[15]

Education for the social services at the technical and vocational level is a very recent development in North America and in Ontario. Ryerson introduced the first two-year course for social welfare workers in 1964. A considerable amount of controversy and confusion surrounds the developments in social work education at this level. Many graduate social workers doubt the adequacy of research concerning the most effective utilization of social workers with different levels of training for designing undergraduate and vocational courses in social work.

Two very different models of curricula in social work are currently being utilized by the Colleges of Applied Arts and Technology in Ontario. The first, developed at the Ontario Hospital in Thistletown over a period of five years, trains child care workers. This course and other similarly specialized courses are clearly at

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15 Oswald Hall, Association of Universities and Colleges of Canada, Manpower Needs in the Field of Social Welfare, Ottawa, 1967, p. 20.

the vocational level. They require graduates to perform clearly outlined functions, usually in a particular setting. The functions are reasonably simple and yet require some basic knowledge of the dynamics of aspects of human behaviour and skills, in this case, of relating to children in a specific setting.

The second model influencing the design of curricula in the CAAT's is the Ryerson Polytechnical Institute course in social welfare. This is a generic course; two years in duration, it is designed to educate and train individuals to function as social workers in any one of a variety of settings. The more specialized aspects of social work in any setting are to be learned on the job in agency programs of staff development, as has been the case traditionally for graduates of the university schools of social work.

The generic model of technical and vocational education is quite controversial among graduate social workers. Some of the M.S.W.'s criticize the course as "a watered-down professional curriculum". They accuse the technical and vocational schools of leading their graduates to believe that they are professional social workers when, in the opinion of these M.S.W.'s, they should not be so considered. And some graduate social workers maintain that they will not be accepted as professional social workers by established social work practitioners or social work administrators.

In fact, many graduate social workers recommend establishing limits on the range of tasks and degree of responsibility allowed to graduates of vocational and college social welfare programs. In evaluating the desirability of such limits, the crucial question is whether those who claim professional training have academic competency that distinguishes them from the vocational or the non-professional. There is significant evidence that even for social workers with the M.S.W. degree, this distinction is not a simple or unambiguous one. Mrs. Dorothy B. Daley, chief author of the influential U.S. Department of Health, Education, and Welfare publication, Closing the Gap in Social Work Manpower, said in an interview with this author that she has seen no statistical evidence that the professionally trained social worker achieves better practice results than the social worker trained on the job. In the medical field, Dr. W. I. Taylor, Executive Director of the Canadian Council on Hospital Accreditation, said in another interview that "the school-trained people have not proven to us that they can do a better job for us". A significant, although probably minority, current of opinion among social work practitioners maintains that personality factors are more important than intellectual factors or formal knowledge in the results achieved in casework.

We conclude from this consideration of social work education

and practice that:

1) Social work educators and practitioners should assign top priority to developing the knowledge base of social work theory and practice. Greatly increased resources must be devoted to research, in close collaboration with other scientific and professional disciplines.
2) Careful research should be undertaken with the aim of defining those situations in social work practice requiring the knowledge and skills of a social worker with a graduate education.
3) Pending careful research of (2), no arbitrary limits should be imposed by law on the responsibilities that social workers trained at the undergraduate or community college level are permitted to bear.

Chapter 2

SOCIAL WORK IN THE HEALTH FIELD

Changing Concepts of Health and Health Care

(See Tables 1, 2 and 3 in Appendix)

> "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."
>
> This widely quoted World Health Organization definition (states Mr. Chauncey Alexander, Executive Director of the Los Angeles Heart Assocation), with the positive and broad goal for the human organism has been accepted generally as the basic concept for the health field. When stated in 1958 it represented both an ideal and a new level of conception about the organization of services to deal with health problems. This conception of "health" arising from new depths of knowledge about health problems and a broadened perspective about the solutions to them implies and encourages a broadened definition of health services.[1]

In the third chapter of its first volume the Hall Commission discusses changing concepts of health and health care. The report makes the point that the doctrine of specific etiology of disease is giving way to the idea that

> ...most disease states are the indirect outcome of a constellation of circumstances rather than a direct

1 Chauncey Alexander, "Theory and Practice in the Health Services", in National Association of Social Workers, Trends in Social Work Practice and Knowledge, New York, 1966, pp. 99-100.

> result of single determinant factors.... The social and psychological, as well as the physical characteristics of the total environment, in large part affect the disease patterns of the community.[2]
>
> In its attempt to control disease, the medical profession today is giving increased recognition to the concept of social medicine, which views man as an integral part of his environment. The practitioner tries to evaluate the health of the individual, not only in terms of symptoms, but by taking into account the physical, biological and social forces which impinge upon the sick person and which may affect the course of his complaint... Modern medicine is increasingly associating mental and physiological disturbances with the emotional tension created by the points of social stress inherent in a rapidly changing and increasingly complex society.[3]

The late Dr. John B. Grant, a leading British authority in the field of public health, describes the implications of new concepts of health as "establishing goals of health care rather than medical care; to provide for the maintenance of health and for rehabilitation back to social usefulness, in addition to the prevention of disease and the treatment of illness."[4]

Consequences of Changing Concepts of Health and Health Care for the Function of Social Work in the Health Field

In its second volume, the Hall Commission discusses the role of medical social workers in the provision of health services:

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2 Report of the Royal Commission on Health Services, Vol. I, Queen's Printer, Ottawa, 1964, p. 98.

3 Ibid., p. 106.

4 Conrad Seipp, ed., Health Care for the Community: Selected Papers of Dr. John B. Grant, American Journal of Hygiene Monographic Series #2XX1, Johns Hopkins Press, Baltimore, 1963, p. 36.

> Social work has an essential role in the provision of good health services; and as the social component in sickness has become more recognized the contribution of the medical social worker has become increasingly more significant. They are employed in hospitals, clinics, and rehabilitation centres and deal with social problems of patients and their families.[5]

Developments in the health field in recent years have seen, in addition to increased emphasis on social medicine, an elaboration of the concept of multi-phased comprehensive health care, with emphasis on prevention and rehabilitation as well as diagnosis and treatment. These developments towards social medicine and comprehensive care have brought attention to the importance of social and emotional factors in health and sickness, and the relevant function of social work in health care.

Other trends in the health care field that have highlighted the functions of social work are: a) increased attention to mental health problems and commitment of resources to their treatment, and b) the trend towards enlarged community health programs.

Historical Origins of Medical Social Work

Most narrowly conceived, medical social work stems from London in the 1870's, where almoners were introduced into hospitals as a form of cost control in the charitable sector of hospital services. Some doctors protested that persons who should be coming to their private offices as fee-paying patients were using the hospital out-patient

5 Report of the Royal Commission on Health Services, Vol. II, Queen's Printer, Ottawa, 1965, p. 63.

dispensaries for free. A special meeting of London's Medical and Chirurgical Society was called in 1870 to discuss the "increasing abuse of this out-patient system". The doctors warned that if relief was too easily obtainable, it would not lead to habits of foresight and self-reliance and would be "detrimental to national life". These criticisms and others led the Charity Organization Society to set up a committee to study the social position of out-patients at the dispensaries in 1872. In 1885 the chairman of the Charity Organization Society proposed setting up the new job of "charitable assessor or coordinator" to examine the eligibility of applicants for free treatment in clinics. In 1895 the first almoner was appointed to London's Royal Free Hospital.

Other forerunners of medical social work that implied a somewhat broader conception of the scope of social work in health settings include: the movement for the aftercare of the insane, which extended from Germany in the early part of the nineteenth century; the visiting nurse movement, which began in England in 1893; and the field training of medical students, which was initiated at John Hopkins Medical School in 1902 by Dr. William Osler, who included social work in the curriculum and assigned medical students as friendly visitors to tubercular families.

Dr. Richard C. Cabot pioneered the introduction of social service departments into American hospitals when he established one

in the out-patient department of the Massachusetts General Hospital in Boston in 1905. Five years later, in 1910, Canada's first hospital social service department was opened in the Montreal General Hospital. The Toronto General Hospital established a social service department in 1919.

Dr. Cabot organized the social service department in the outpatient facility of the Massachusetts General Hospital to

> serve the patient in his real trouble, whatever that might be... Real trouble is understandable and helpable only when you know...bodily states...mental states...bodily environment...and mental environment..[6]

Most doctors tend to limit the function of social work in the general hospital to achieving environmental manipulations for poor patients when social circumstances are undermining medical treatment. Miss Laura Jackson in her book, Hospital and Community, makes the point that in 1937 an authoritative study of the attitudes of doctors devoted only one page to medical social work and introduced it by a subhead, "The social worker arraigned as an element of confusion."[7]

The majority of physicians in 1937 held a very narrow and unfavourable opinion of social work in the hospital, and if the majority of physicians today do not display a similar attitude they are still not as enthusiastic about the function of social work in the hospital as were pioneers such as Dr. Cabot and Dr. Malcolm P. MacEachern. The

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6 Richard C. Cabot, quoted in Laura Jackson, Hospital and Community, Macmillan, New York, 1964, p. 91.

7 Ibid.

latter, in 1935, wrote an authoritative text on hospital organization and management, in which he predicted:

> In the future, the medical social worker will be as valuable in supplementing the work of a specialist practising exclusively among the wealthy as she has been, and is, to physicians caring for the sick who are financially less fortunate.[8]

Conflict and Consensus among the Professions Concerning the Proper Function of Social Work in General and Psychiatric Medical Settings

1. Social work: generic or specific

The formal position of the social work profession is that social work in whatever setting it is practised is basically generic - that is, the elements of practice common to all settings are far more significant than the elements particular to any one setting.

A significant minority, however, (about 30 per cent) of social workers practising in the medical and psychiatric settings, consider their work sufficiently different from social work practised in any other setting to warrant specialized education and registration as medical or psychiatric social workers.

Two documents published by the Canadian Association of Social Workers present the official viewpoint on the functions of the profession in the health field. They, of course, do not distinguish between general and psychiatric medical settings. The first is entitled "A Statement of Standards to be Met by Medical and Psychiatric Social

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8 Malcolm P. MacEachern, Hospital Organization and Management, 2nd ed., Physicians Record Company, Chicago, 1935. Quoted in Laura Jackson, op. cit., p. 418.

Service Departments in Hospitals, Clinics and Sanatoria." This was first published in 1952 and reprinted in 1965. The second is entitled "A Statement for Social Workers on Functions and Standards of Social Work Practice in the Health Field." This was published in 1967. In the excerpts that follow, I have combined points from the two publications:

> Modern doctors appreciate the contribution of social work as an aid in diagnosis and rehabilitation, and there is more and more understanding of the ways in which social work can contribute toward the patient's ability to accept and profit by treatment...
>
> With the trend toward treatment in the community rather than in hospital or other institutions, integrative and interpretive services provided by social work are increasingly necessary.
>
> The social worker in the health setting recognizes the medical administrator's chief responsibility as the efficient and economical use of facilities...
>
> Casework service to the individual patient is the primary and fundamental activity of the department. The sharing of information between the doctor and the social worker is basic to the individual understanding of the patient. It is a collaborative activity of team-members functioning together in the interest of the patient and the persons important to him. Treatment is, therefore, a flexibly adaptive process.
>
> Casework services may range from giving concrete suggestions for dealing with a simple problem to collaborating with a doctor in the treatment of severe psychiatric problems or helping the patient to face reality factors of permanently disabling illness. The resources of the patient and his immediate environment are primarily used in giving help, and frequently these are suplemented by the use of community facilities. The quality of casework service is measured neither by its duration nor by its complexity, but by the recognition of human beings as individuals, each reacting to a given situation according to his own need and with a

right to determine for himself, to the extent that he is able, the solution to his problem...

The social worker who has been trained in specific skills for securing pertinent history shares with other members of the professional team responsibility for securing the material necessary to acquire dynamic understanding of the patient and his family, for appraising the social data, enlisting the help of persons important to the patient, and in preparing them for his treatment and its implications.

From the beginning, the social worker contributes to the understanding of the patient's emotional problems and of his life situation. In addition, he suggests areas in which social work skills can be utilized in obtaining the treatment goals. It is essential to maintain the principle of differentiation of professional function, recognizing that medical or psychiatric diagnosis and medical treatment or psychotherapy are primary responsibilities of the doctor, just as the practice of social work is the major contribution of the social worker. Whatever the major treatment emphasis, the doctor assumes psychiatric and medical re sponsibility for each patient.

2. Conflicting expectations concerning the role of social workers in a general hospital

An important study of role expectations for social workers in a university hospital amounts to a study of conflict between physicians and social workers.[9] The authors found considerable disagreement between doctors and social workers about the social workers' tasks and inaccurate perceptions of the extent of the disagreement between the professions. The prevailing situation facing social work

9 Katherine M. Olsen and Marvin E. Olsen, "Role Expectations and Perceptions for Social Workers in Medical Settings:, Social Work, Volume XII, No. 3, July 1967, pp. 70-78.

in the hospital setting is summarized in the article:

> In a hospital setting, where life and death are crucial concerns, the physician must of necessity have dominant authority. The formal authority granted him by society in the hospital, plus the high informal prestige enjoyed by the medical profession, means that the physician's role will normally overshadow other professional groups working in the hospital. Therefore, the social worker must function within an authority system that places his profession in a subordinate position and forces it to carve out for itself whatever professional responsibilities it assumes; and when it does assume certain responsibilities, it often lacks the recognizable authority to carry out these activities adequately. Social work continually must demonstrate the value of its services to the medical profession and to the hospital, which places it in a perpetually defensive position.[10]

The authors of this study interviewed sixteen full-time social workers and forty-five physicians at the University of Michigan Medical Centre in the spring of 1965. Both social workers and doctors were presented with a list of sixteen activities. For each activity, all the individuals were asked:

> 1) whether social workers <u>should</u> take working responsibility for carrying out the task, and
>
> 2) whether they believed members of the <u>other</u> profession thought that social workers should take working responsibility for carrying out the task.

The study revealed that the majority of doctors would restrict the responsibility of social workers to manipulating the social environment of the patient to facilitate his recovery, rehabilitation and continuing health.

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10 <u>Ibid.</u>, p. 71.

Only in five areas of responsibility was there agreement among the majority of doctors and social workers that the area was properly the working responsibility of social workers. These were

1) Gathering social histories of patients to supplement medical histories.

2) Helping families of patients with social problems related to the patient's illness, disability, or impending death.

3) Helping patients with social problems related to their illness, disability or impending death.

4) Making referrals to, or arrangements with, appropriate community agencies regarding custodial, convalescent, or institutional care for patients who require post-hospital care.

5) Making referrals for community services (visiting nurse, visiting teacher, family counselling service and the like, for patients returning home after discharge from the hospital).

One illustration of the extent of conflict in the expectations of the medical and social work professions as to the proper function of social work was that, although a large majority of physicians expected social workers to assume working responsibility for securing financial assistance for patients when it was needed, a majority of social workers rejected this responsibility as inappropriate for their role. On the other hand while only 13 per cent of the physicians thought that social workers should help patients with their emotional problems and only 50 per cent thought that social workers claimed to be competent to help patients with emotional problems, of the social

workers interviewed over 95 per cent believed that emotional problems of patients should be within their working responsibility, and 60 per cent believed physicians were willing to grant them responsibility in this area!

Less than 25 per cent of the physicians, but 100 per cent of the social workers, considered that helping patients adjust to the hospital should be part of the social workers' role. Sixty-six per cent of the physicians expected social workers to claim working responsibility for this task. Strikingly, over 80 per cent of the social workers believed that physicians were willing to delegate the task to them. The article concludes:

> physicians apparently see medically related emotional problems as an essential part of the patient's over-all condition for which they hold themselves responsible. Social workers, however, define this activity as one of the professional services they are particularly competent to provide.[11]

Another source of conflict between highly skilled social workers and physicians in a hospital, in addition to the scope of the working responsibility that the social worker should take, is the aspiration of many of these highly qualified social workers for an independent final judgement in the practice of social therapy. Many graduate social workers insist that social work in the health settings should not be considered a paramedical profession of the order of nursing, physiotherapy or laboratory technology. They maintain that, while

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11 Ibid., pp. 77-78.

the nurse or therapist cannot demand an independent final judgement in her field of practice, the social worker must insist on it in his field.

As we have seen, the graduate social worker often views his function as that of a skilled therapist concerned more with the intra-psychic and interpersonal aspects of the social problems of medical patients than with the financial and material aspects of the social problems. Many social workers consider doctors, for the most part, uninterested in and having no special competence to treat the emotional and environmental factors in a patient's medical condition. The realization of these aspirations of some of the more professionally self-conscious social workers for final say in social therapy would require institutionalization of the team approach to diagnosis and treatment in the general hospital setting. Although the team approach has been instituted in several mental hospitals, it is very rarely found in the general hospitals. The doctor, whether specialist or general practitioner, is used to assuming full and exclusive responsibility for his patients during the period of their hospitalization. To the extent that he is with increasing frequency utilizing the services of other professions and occupations, he does so for technical or clearly defined and limited purposes and expects in most cases (at least formally) to maintain full authority over the nature and duration of the services provided by ancillary groups. The doctor often

takes a similar attitude towards social work for his patients.

If, in spite of these attitudes of most private doctors and many staff doctors working in the hospital, a good deal of medical-social work involves complex social and emotional problems and significant autonomy for the social worker, it is because 40 to 50 per cent of social work services are typically provided to outpatients, many of whom have no private doctor. Many inpatients on the public wards may also have no private doctor and the staff doctors may be more willing to refer these patients to social workers when a relatively complex social or emotional problem is known or suspected.

3. Medical proponents of a broad role for social workers in the general hospitals

It would seem that Dr. Cabot envisioned a broad and important function for social workers in the outpatient departments of hospitals. He believed that "the modern doctor is afflicted with blindness to background". Dr. Cabot reflected:

> I see a case of phthisis (deterioration in the lungs) in a sad eyed Irishman. But I cannot see as he does his children at home, the coldness of his employer when he asks if his job can be kept for him, the dreariness of this great hospital with its suggestion of nameless horrors behind the doors which open for a moment and are swiftly closed again. The self that is pushing

> painfully through these experiences I fail to see, though it is all written in the stoop of his shoulders, the fear in his eyes, and the swift snatches of hesitating speech as he questions me about his lungs.[12]

Dr. Cabot wanted to enlist the aid of the social worker in asking "What is missing here from the essentials of the human life?" He envisioned this function as especially crucial in the special clinics of the outpatient department for low or middle-income patients without a regular family physician or private specialist.

Dr. E. M. Bluestone, Director of the Montefiore Hospital in New York from 1928 to 1951 and presently Assistant Professor of Hospital Administration at New York University, is a strong contemporary supporter of medical social service.

> The doctor and the social worker in our complicated society need each other. One must remember that birth, growth, illness and death are broadly social, rather than strictly biological phenomena...
>
> ...she (the medical social worker) is in a better position as to time and opportunity to relate him and his medical burden to the environment from which he came and to which he must return with safety, after the required adjustments have been made... The penalty of failure in joint social and medical effort is seen too often in the advent of complications, chronicity, relapses, and sequelae - and quite possibly death... Social dependence as a complication...must also be foreseen and prevented, either through education, change, or intelligent subsidy - and sometimes all three.

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12 Hugh J. Cabot, Social Science and the Art of Healing, Dodd, Mead and Co., New York, 1931. Quoted in Laura Jackson, op. cit., p. 419.

...As a rule the social worker has a sharp appreciation of the doctor's healing powers but the doctor does not seem to have the necessary awareness of the position which the social worker can occupy productively alongside of him.

...A thoughtful physician once remarked that "lots of good medicine goes down the drain because of the absence of social service".

...The late Isaac Hirsch, M.D. of New York, once did a small masterpiece of sculpture which he called "Discharged Cured" showing a bowed and lonely little man leaving the hospital with a bundle under his arm. Cured - for the moment perhaps - of his illness, but bewildered as he returns to the outside world and to his doubtful future.

...Naturally, I would prefer to have every physician act as his own social worker, but practical considerations make this undesirable beyond a certain point where he finds himself lacking in the necessary skills and the knowledge of social resources as well as time.[13]

4. Further comments on the contemporary position of social workers in Canadian hospitals

In a recent interview, Dr. W.I. Taylor, Executive Director of the Canadian Council on Hospital Accreditation, reflected on the role of social workers in the general hospitals.

Dr. Taylor felt that trends were under way - both in the attitude of the doctor towards illness in a patient, and towards the relationship of his role with others in the care of a patient's health, as well as in public policy - that were having the cumulative effect of creating an upward trend in the acceptance of the need and effectiveness of collaborating with other disciplines such as social work in

13 E.M. Bluestone, M.D., "The Social Worker and the Physician", in Hospitals, March 1962, pp. 369-75.

the medical field. "In the old days", Dr. Taylor said, "the doctor took the attitude 'I don't need anybody else; if I do my job well, that is all the patient needs'. Nowadays there is more and more consultation and more and more conferencing about patient care."

However, Dr. Taylor stressed, as well, that the social worker must be prepared to accept limitations on his autonomy in the hospital. He said that there was a need for people to keep in mind that everything in a hospital happens on a doctor's orders. "If the social worker intervenes in a case without the knowledge or the orders of a doctor, or follows through when it is not prescribed, conflicts are created with the nurses or the doctors."

Dr. Taylor also feels that some adjustment is required of the social worker coming from a community agency setting where he has had primary responsibility for a case, into the hospital where he has to get used to working "at close hand with other disciplines in a position closer to that of an auxiliary than to that of an independent professional with full responsibility for a patient".

If certain changes in medical practice and public policy tend to increase the demand for social work services in hospitals, it is interesting to speculate on the possible effects of Medicare in decreasing demand for social work services stemming from outpatient departments and public wards. As health insurance becomes more widely held and more low-income families have their own family doctor and access to private specialists, some social work educators

believe that this will tend to lessen demand for social work services in the hospital. These social workers believe that trends to shorter periods of hospitalization and greater emphasis on home care work in the same direction. They see an increased demand for trained social workers as consultants and supervisors for community-based health programs.

5. Other obstacles to increased demand for medical social work

Obstacles to the extension of skilled social work services to patients in the hospital or community whose social problems are not associated with financial difficulties come from sources other than physicians. Patients themselves, in the middle-income levels are reluctant to accept the services of social workers.

A family health maintenance demonstration[14] at Harvard University found that

> social service was <u>not</u> regarded by patients as part of the health service. It was identified with poverty and the depression. The social worker's services were underutilized in spite of the fact that her job and availability were made known to all the studied families.

The study was also critical of certain traits exhibited by many of the social workers.

> The social workers in the study were found to stick to their offices, play the role of amateur psychoanalysts, were not family-centred and tended to be disease-oriented in their assessment of family relationships.

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14 Reported in Samuel Wolfe and Genevieve Teed, <u>A Study of the Work of a Medical Social Worker in a Group Medical Practice</u>, Saskatoon, 1967, mimeo, pp. 86-87.

In his skilled analysis of the study, one of the participants, Dr. Eliot Freidson, suggested that the social worker was not utilized because his role was seen as that of a specialist and not as a person (such as the nurse) to whom one went with everyday problems.

Dr. Silver, the study director, suggests a need for more critical self-study by social workers of the way their role is seen. He suggests the development of family casework techniques analagous to family medical practice techniques, and raises the question of whether the public health nurse could be trained to do casework.

6. Does more social work mean more social workers?

Silver's suggestion to train public health nurses to do casework introduces an important idea. Although we have made it clear that emphasis on social medicine and comprehensive health care highlighting the multiple functions of social work in the health field, we should also stress clearly that several types of personnel can and do perform social work functions. It remains to be seen to what extent social work in the health field will be performed in the future by physicians in family practice, with increased knowledge and skill in psychiatry, by public health or psychiatric nurses trained in casework methods, by high-school or college graduates in liberal arts trained by the health settings to provide simple social work services, or by graduates of the different streams of social work education.

We have only entered a period of essential research and demonstration to define casework, to distinguish levels of complexity and criticality in casework, to assess the possibilities of specialization for social workers by level of responsibility and by setting, and to design programs of education and training appropriate to different job categories. This experimentation appears necessary and healthy and results should not be anticipated by an early and arbitrary restriction of certain functions to social workers with specific types of education.

Inasmuch as research and experience indicate that social work personnel with a specific type of formal academic training in social work perform certain tasks more capably, employers in the field can be expected to govern their recruiting policies in that light. In circumstances where social stress and client vulnerability are both very great and it is evident that risks to the patient or client's health can be minimized through the services of social workers with a Master of Social Work degree, it will then be necessary to make these services available to the client or patient.

7. Social work in psychiatric settings

So far the discussion of social work in the health field has centred primarily on the general hospital setting. However, more social workers at every level of training are found working in mental and psychiatric hospitals, although of course there are far fewer beds in these institutions than in general hospitals. In addition many

(20 per cent to 30 per cent) of the social workers in general hospitals are working full-time in the psychiatric departments or mental health clinics of these institutions. The attraction to work in psychiatric settings may be explained in part by the interest social workers have in the types of illness and the treatment methods characteristic of these institutions. Furthermore, of all the branches of medical specialization, psychiatry is best prepared and most inclined to make use of the knowledge and skill of the social worker.

On the part of social workers there is more willingness to accept the leadership of psychiatrists than of other physicians. Most social workers view their special area of competence as diagnosing and treating individuals and families whose social or emotional problems are blocking their self-fulfilment or their capacity to function adequately as members of society. In this commitment their goals and, frequently, their methods are shared more with psychiatry than with the other branches of medicine. Furthermore, they recognize that the psychiatrist is trained to an even more specialized and competent degree in this field, while, on the other hand, many social workers regard most other physicians as generally uninterested and not especially competent in diagnosing or treating the social and emotional aspects of a patient's medical condition.

Another factor explaining the atraction of employment in a mental health institution for social workers is that the "team" approach to diagnosis and treatment is far more highly developed in many of the mental and psychiatric hospitals than in almost any of the general

hospitals. Thus the skilled social worker often feels that his training is being more fully utilized.

8. Disagreement and competition among the professions in the psychiatric settings concerning one another's function

In the psychiatric settings, as well, there is some disagreement and competition among the principal professions - psychiatry, psychology and social work. There is also considerable confusion about the extent of this interprofessional rivalry.

Two important studies of relationships among the professions in mental health settings reach opposite conclusions on the extent of agreement between psychiatrists and social workers about the proper function of social work. One study concludes

> Social workers and psychiatrists indicate a lack of consensus regarding the definition of the social worker's role. The social workers argue that their role is one of collaborative treatment with families; psychiatrists argue that it consists of welfare services.[15]

The second study concludes that:

> The members of the two professions (psychiatry and social work) have a clear comprehension of the functions included in one another's roles... The two are in close agreement that psychiatrists can provide information about: neurology; psychopathology; psychological theory; clinical skills; therapeutic skills; and diagnostic methods. Both agree that the social worker has the special functions of providing: knowledge of the family; knowledge and use of community resources; and understanding of the influence of environmental factors in mental health.[16]

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15 William A. Rushing, The Psychiatric Professions; Power, Conflict and Adaptation in a Psychiatric Hospital Staff, University of North Carolina Press, 1964.

16 Alvin Zander et al., Role Relations in the Mental Health Professions, North Holland Publishing Co., Amsterdam, 1957, p. 42.

(The first study was conducted in a psychiatric teaching-hospital and the second among psychiatrists, psychologists and social workers practising in a group of hospitals in a large city.)

Although differences in viewpoints and conflicts over the proper amount of responsibility for diagnosis and therapy to be accepted by the various professions exist in mental health settings, the members of all three professions readily recognize that they are mutually interdependent in making a complete differential diagnosis and in carrying out the various aspects of comprehensive treatment. The author of the second study, finding a good deal of agreement between psychiatry and social work on one another's functions, concludes that:

> There are unsettled issues among psychiatric social workers concerning the functions they should perform. The impression one derives is that the members of this profession wish for more responsibility even though they readily accept their status as an ancillary group to psychiatry.[17]

Although the exact extent and limits of cooperation and conflict among the professions in the mental health settings is not fully known, it is a fact that many mental hospitals and psychiatric hospitals have institutionalized sophisticated procedures for collaboration among psychiatrists, psychologists and social workers in diagnosis and treatment. In some mental and psychiatric hospitals (still a minority), case conferences are held at the time of admission, several weeks

17 Ibid., p. 85.

later for diagnosis and formulation of the treatment plan, at regular intervals or crisis points during treatment, and before discharge to plan for after-care if necessary. Members of all the principal professions in the setting attend these conferences and participate in decisions.

Specialized Education for Medical and Psychiatric Social Work?

We have already mentioned that the terms "medical" and "psychiatric" social work, although in common use, have usually been held by social work educators and administrators to refer only to the setting in which social work is carried on.

Some of the most advanced practitioners in the medical and psychiatric settings, as well as some important social work educators, have, however, stressed the desirability of more specialized formal education in those areas of theory and method which are or could be developed to be of specific relevance for the practice of social work in the different settings. At present majority opinion seems to doubt the practicality of such specialized education. But there is a growing demand from medical and health settings themselves upon the schools of social work to develop specialized materials and sequences of courses for the practice of social work in these settings. It is to be hoped that in the fundamental reconsideration of the structure and content of social work curricula now in progress, renewed attention will be given to the desirability of developing such

specialized materials and sequences. Later in the conclusions we present an argument for developing an internship program for graduate social workers intending to practise in general medical settings. We are nevertheless aware that the merits of specialized education in medical social work, not to mention the content and location of such programs, require further consideration. But we are firmly convinced of the necessity to assess the almost ritualistic position favouring the generic approach to social work reiterated by many in social work education.

It will be our argument that current trends, both in social work education and in medical practice, increase the need and opportunity for some kind of specialized education in the theory and skills for social work practice in health settings.

Chapter 3

SOCIAL WORK IN THE HEALTH FIELD - THE ONTARIO PICTURE

Data Sources

In Ontario, a variety of health insitutions offer social work services. They are organized in many different ways and a variety of personnel provide them. General, mental and psychiatric hospitals employ social workers, as do sanatoria, specialized health societies, local departments of health and (in other parts of Canada) physicians working together in group practice.

Data on the number of social workers employed in health settings in Ontario, the educational qualifications of these social workers, and the methods of organizing and delivering social work services in the health field, were obtained in three ways.

First, reports to the Ontario Hospital Services Commission by the general and special hospitals (including psychiatric hospitals not included in the Ontario Hospital system) were analyzed.

Second, lists were tabulated of both the members of the social work section of the Ontario Hospital Association and social workers

employed by the Department of Health in the Ontario Hospital system.

Third, returns from a Committee on the Healing Arts questionnaire sent to administrators of social work agencies and hospital departments also were analyzed.

There was an impressive, although not complete, consistency in the data from these three sources regarding the numbers and qulifications of personnel employed as social workers in Ontario's general and mental hospitals.

The Number of Social Workers in General Hospitals

Of 215 general, convalescent and chronic hospitals, less than one-quarter (fifty) report a social service department employing at least one social worker full time to the Ontario Hospital Services Commission. Twenty-three of these employ a single social worker, thirteen employ two, and only fourteen employ more than two social workers on a full-time basis.

We derived Table 4 from returns by hospitals to the Ontario Hospital Services Commission, using the Commission's classification of hospitals. Table 4 indicates the number of social workers and the social worker:bed ratios for each class of hospital.

The Hall Commission noted that in 1961 there were no hospitals in Canada with under 100 beds reporting a social service or social work department. Six years later, there were two hospitals in Ontario with under 100 beds, and five with under 200 beds that

operated a social service department employing at least one social worker full time.

The overall social work personnel:bed ratio in Ontario for public general (non-psychiatric) and public special hospitals is 1.337. The three Ontario general hospitals with the highest caseworker:bed ratios are the Ottawa General, Kingston General and Toronto General Hospitals - all three of these approximate a social worker:bed ratio of 1:70.

On the other hand, several large hospitals have a social worker:bed ratio of less than 1:500. These include the Oshawa General Hospital; St. Joseph's Hospital, Hamilton; St. Joseph's Hospital, London; St. Joseph's Hospital, Toronto; Toronto East General and Orthopaedic Hospital; Toronto Western Hospital; and St. Michael's Hospital, Toronto.

(Ontario general hospitals reported twenty-five part-time social work employees and these part-time workers have not been included in the number of hospitals with social work departments, nor in the ratio of social workers:beds.)

Rate of Increase over the Last Five Years

To measure the rate of increase in the employment of social workers in general hospitals over the last five years, we selected a sample of twenty-three hospitals from the group of hospitals employing at least one full-time social worker, as reported to the Ontario Hospital

Services Commission on December 31, 1966. The 1961 returns to the Commission from these hospitals were examined. Of the twenty-three hospitals, nine reported no social workers employed full time on December 31, 1961. In the remaining fourteen hospitals, fifty-nine social workers were reported in 1961 and seventy-eight in 1966. (In 1961, forty-five were reported to be "qualified", and in 1966, fifty-four).

For the set of twenty-three hospitals reporting a social work employee on December 31, 1966, the overall rate of growth in social work employees over the five year period was 47 per cent. For the group of fourteen hospitals with a social service department established prior to December 31, 1961, the rate of growth for the five-year period was 30 per cent.[1]

Educational Qualifications of Social Workers in the General Hospitals

From an analysis of the application forms of members in the medical social work section of the Ontario Hospital Association, the following distribution of members by educational background was tabulated: Master of Social Work degree - fifty-seven, or 29 per cent; Bachelor of Social Work degree - sixteen or 8 per cent; Social Work Diploma or Certificate - twelve or 6 per cent; Nursing degree - forty-one or 21 per cent; Bachelor of Arts degree or high school diploma - sixty-nine, or 35 per cent.

1 The change in the proportion of social workers reported as "qualified" over the five year period was -4 per cent, a decline from 77 per cent to 73 per cent).

Thus, only 43 per cent of the members of the medical social work section of the Ontario Hospital Association report any formal training in social work. Yet, hospitals report to the Ontario Hospital Services Commission that 70 per cent of the social workers are qualified. Inasmuch as the Ontario Hospital Services Commission recommends to hospital administrators that they use the criteria for eligibility in the Canadian Association of Social Workers as the standard of qualification (as of 1964 only social workers with the Master of Social Work degree have been eligible to become new members of the Association), the discrepancy of 41 per cent in the proportion of M.S.W.'s among members of the OHA social work section, and the proportion of "qualified" social workers among full-time social workers reported by hospitals to the OHSC, must be explained. In part it is accounted for by the terms of the grandfather clause in the new membership eligibility criteria defined by the Canadian Association of Social Workers in 1964. As well, the medical social work section of the Ontario Hospital Association includes many nurses who are providing some social services in hospitals which do not have a social service department. These caseworkers are interested in keeping abreast of developments in medical social work and many of their hospitals may, in fact, be contemplating the establishment of a department, but they would not be included in the returns to the Ontario Hospital Services Commission.

Returns (representing between 80 per cent and 90 per cent of the social workers employed in general hospitals) from the questionnaire sent by the Committee on the Healing Arts to administrators of hospital social service departments indicate that approximately 53 per cent of the social workers in general hospitals have a social work degree or diploma. In social work departments with more than two full-time social workers, the proportion of social workers with formal education in social work rises to 61 per cent. The proportion of nurses in social service departments of hospitals with two or more full-time social work personnel is only 6 per cent.

A Brief Sketch of the Volume, Organization and Nature of Services Provided by the General Hospital Social Service Departments

Analysis of the returns to the administrators' questionnaire from several of the hospitals in Ontario with long-established social service departments offering a wide range of social services, shows a great variety in the methods of organizing and operating these departments.

Social services provided to the outpatient facilities of the hospital as a proportion of the total volume of social services rendered in the hospital, ranges from 20 per cent to 50 per cent. Most of the hospitals fall in the range from 40 per cent to 50 per cent. A large, although unspecified, additional percentage is done on the public wards. Relatively little casework is done in the private or semi-private wards.

For this same small group of hospitals, the proportion of cases opened in the social service department to the number of admissions in the year 1966, ranges from 2-1/2 per cent to 7 per cent.

Social work functions in Ontario general hospitals are organized in a wide variety of ways. In some of the smaller and outlying hospitals, the director and assistant director of nursing may provide whatever social services are offered, mainly in the form of referrals to appropriate agencies in the community. In other smaller hospitals a part-time or full-time registered nurse may be employed to handle admissions, discharges and referrals to community agencies, although she will not do any casework.

In some hospitals, the social service personnel will be administratively responsible to a variety of departments in the hospital. Some will be responsible to the outpatient mental health clinic, others to the psychiatry department, to the chronic unit or to the active medical units.

In other hospitals there is a unified social service department to which all social workers are directly responsible, and referrals to the social service department are made by staff doctors, residents, nurses, community agencies or patients themselves.

By and large, social workers in the general hospitals are not

incorporated into treatment teams. Very few referrals for social work are made on the basis of discussions held in regularly scheduled conferences or on ward rounds.

In Cornwall, plans are being laid for a sharing arrangement among the Cornwall General, Hôtel Dieu and Winchester Memorial Hospitals to provide social work services for the patients of these hospitals.

Estimating Training Needs for Social Workers in the General Hospitals

We have already observed that only five hospitals in Ontario with fewer than 200 beds have a social service department employing at least one social service worker full time. We have observed also that several very large hospitals have only nominal social service departments and a social worker:bed ratio of less than 1:500, in contrast to the ratio of 1:70 in the hospitals with the highest ratios.

Problems of evaluating the need for personnel in the health field have been much discussed. These problems are no less acute for social workers. We have outlined some of the recent trends in the concepts and methods of health and health care that emphasize the social and emotional aspects of physical and mental health, indicating the potential functions of social work in health settings and increased demand as well as perception of need for social work personnel. We have also examined the difficulties in associating demand for any particular type of social service personnel with this

increased demand for social work services.

Several important studies have nevertheless indicated a serious and increasing shortage of trained medical social workers. As far as the immediate shortage of medical social workers is concerned, the Hall Commission said in 1961:

> It is evident that shortages of these personnel exist. In 1961 there were 51 full-time vacancies or 14% of the positions established for social workers unfilled in public, federal, and private hospitals. With the Commission's recommendations to establish home-care and to treat more mental patients in general hospitals and in the community, there will be a still greater need for medical social workers, both to help discharge patients and to assist their families. Methods must, therefore, be devised of overcoming existing and future shortages of these personnel.[2]

In 1967, on the basis of returns to the questionnaire for administrators of social work agencies, there were approximately fifty vacancies among the 210 budgeted positions for social workers. This is approximately 24 per cent. Similar, although slightly lower, percentages of unfilled budgeted positions apply in the mental and psychiatric hospitals. Several hospitals indicated in writing that for a variety of reasons they had been unable to secure the services of a qualified social worker, although they had attempted to to so and although the need for such a person in their hospital was

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2 Report of the Royal Commission on Health Services, op. cit., p. 64.

clear. Most of these hospitals are in northern Ontario.

A report of the Presidents Research Committee to the Committee of Presidents of Universities of Ontario in June, 1966 discusses the medical social work situation in Ontario:

> Adequately trained medical social workers are rare and the demand is great. At present, a medical social worker requires a B.A., graduate training in a school of social work and supervised clinical experience. No formal program in medical social work exists.
>
> There is a need for shorter programs, possibly at the undergraduate level, and a number of Ontario universities are considering the establishment of programs leading to a Bachelor's degree in social work. Students in such courses would be encouraged to acquire practical experience in medical or other settings during the summers between undergraduate years. Training grants for this important practical component of their education would be essential. Establishment of new programs of social work in collaboration with, or as an integral part of a health science centre, would provide medical experience for students in social work as well as opportunity to study the role of the medical social worker in the delivery of health care.[3]

The report of the National Commission on Community Health Services in the United States discusses training needs for social workers in the health field:

> ...The shortage of trained social workers, for example, is one of the most acute in the health field ... Vigorous efforts, voluntary and governmental, must be

3 Presidents Research Committee, The Health Sciences in Ontario Universities, Committee of Presidents of Universities of Ontario, Toronto, 1967, p. 14.

undertaken to increase the supply of professional social workers in medical and health services through the construction of expanded and new educational facilities; financial support for faculty field instructors and related costs of teachers; greatly increased scholarship aid through fellowships and traineeships; and research and experimentation in methods of professional education aimed at innovations intended to improve the quality of professional education of social workers for medical and health services.

There should be increased training for social workers in medical and health settings, where training is community oriented and provided in concert with other members of the health team. In addition, since it is probable that graduate schools are not going to produce enough social workers to meet the increasing needs in this field, research and demonstration must proceed toward a teaching program to train personnel of less than professional skills to perform limited duties within the health team.[4]

Returning to the question of measuring the need for social workers in the general hospitals and establishing quantified standards, the Hall Commission had this to say:

As needs for personnel in this field vary between hospitals, depending on the type of hospital, its location, and the proportion of in-patient to out-patient services, it is difficult to establish a standard by which the adequacy of our supply of medical social workers may be determined...[5]

In 1965 the Canadian Council on Hospital Accreditation included, for the first time, a statement on social work in a cautiously worded

4 National Commission on Community Health Services, Health is a Community Affair, Harvard University Press, Cambridge, Mass., 1966, p. 96.

5 Report of the Royal Commission on Health Services, op. cit., p. 64.

and extremely influential statment:

> ...formally organized service of social work under the direction of a qualified worker would appear to be appropriate for most larger general hospitals and for many specialty hospitals, particularly those established for care of long-term illnesses.[6]

A somewhat more demanding standard, albeit for a limited region, is the recommendation of the Committee for the Survey of Hospital Needs in Metropolitan Toronto:

> Each hospital with over 100 beds establish a social work department and staff it with at least one qualified social service worker.[7]

The report of the Committee on Medical Auxiliaries to the Ministry of Health in the Department of Health for Scotland, presented in 1951, includes a statement on the need and demand for almoners or medical social workers:

> In hospitals at the present time the need for the services of almoners varies according to the type of hospital: (a) in teaching and other general hospitals receiving in the main acute cases, the requirement has been estimated by the Institute of Almoners at one almoner to every 50 beds. Hospitals with a smaller proportion of acute beds might manage, it is thought, with one almoner to every 100 beds. We have no evidence that special hospitals differ in their requirement as regards the proportion of almoners to beds; and it would appear, therefore, that as a working average, for purposes of calculation, the assessment should be one almoner to every 75 beds in hospitals dealing with acute cases.[8]

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6 Canadian Council on Hospital Accreditation, Standards for Accreditation of Canadian Hospitals, 3rd ed., 1965, p. 6.

7 Committee for the Survey of Hospital Needs in Metro Toronto, Report, p. 26.

8 Department of Health for Scotland; Reports of the Committees on Medical Auxiliaries, Her Majesty's Stationery Office, London, 1951, p. 26.

We have noted earlier that for large teaching hospitals in the urban centres of Ontario, with long-established social service departments offering a wide range of services to both outpatients and inpatients, a recurring ratio has been observed of one full-time social worker (or the equivalent in part-time social work staff) for each seventy-five beds. It should be repeated that this 1:75 ratio is observed in large urban teaching hospitals.

Dr. W. I. Taylor, Executive Director of the Canadian Council on Hospital Accreditation, believes there is a greater need for medical social workers in urban centres where there are more pockets of population with below average income and the attendant social problems. In addition, since many family practitioners do not have appointments in the city hospitals and a patient may not be looked after by a family doctor while hospitalized, social workers may be needed to attend to the personal care of the patient during hospitalization. Dr. Taylor feels that this problem is not as great in rural areas where hospitals are staffed by general practitioners who know the social needs of their patients and are sensitive to them.

The Hall Commission also discusses the problem of providing social services in small hospitals with under 100 beds:

> While it may not be feasible for small hospitals to employ a full-time medical social worker, some system must be devised to ensure that the services of a qualified social worker are available to patients at these hospitals. One such arrangement is for

these hospitals to employ social workers on a part-time basis. Alternatively, this service could be organized regionally with the social workers being attached to a county health unit or regional welfare office.9

9 Report of the Royal Commission on Health Services, op. cit., pp. 64-65.

Chapter 4

SURVEY OF SOCIAL WORKERS IN ONTARIO

The Sample

In addition to the survey of social work administrators, the Committee undertook a mailed sample survey of Ontario social workers in the summer of 1967. The sample was composed of two parts:

> 1) Fifty per cent of the membership of the Ontario Association of Professional Social Workers in all settings other than hospitals. This sample was drawn from the membership register of the Ontario Association of Professional Social Workers in Ottawa, after removing the names of those social workers in hospitals who are also members of the association.
> 2) One hundred per cent of professionally trained social workers in the general hospitals and mental hospitals. This second part of the sample was restricted to social workers in the hospital settings with some professional training (either in social work or nursing) and excluded social workers or social work assistants with liberal arts or high-school education. This second part of the sample was compiled from master lists of social workers in the hospital settings provided by the Ontario Department of Health and the Ontario Hospital Association.

The final sample was composed of 380 social workers drawn from the membership file of the Ontario Association of Professional Social Workers, 119 social workers in general hospitals, and 127 social workers in the Ontario Mental Hospital system. The total

sample comprised 626 social workers and returns were received from 370, or 59 per cent.

The aims of the survey were largely descriptive. It was designed to provide information on the backgrounds and work patterns of trained social workers and to examine the extent and nature of differences in these variables between the major settings employing social workers. It must be kept in mind that this survey deals only with social workers eligible for membership in the professional association (with some exceptions in the hospital settings). Thus it is drawn from only 25 per cent of those employed in social work positions in Ontario.

The report on the findings of the survey of social workers will be organized in the following way: data on the numbers and qualifications of social work personnel in the major Ontario settings are presented in Table 3. Tables 5 through 10 describe the distribution of the sample on some of the important background characteristics. We shall discuss some of the interesting findings which come to light by relating these background attributes. Finally, we will report on the major findings concerning the interprofessional relationships of social workers in the health settings only. Where it is desirable to illuminate the meaning of these data, we will contrast the findings for social workers

in health settings with the findings for social workers in other settings.[1]

Relationships among Background Variables

1. Sex and age

When sex and age were related, it was found that in only one age group (forty to forty-nine) were the number of males and females equal. For social workers over fifty, the ratio between females and males was almost 9:1; for social workers under forty, the ratio was 2:1. In the forty to forty-nine group, however, the ratio was 1:1 - there were fifty-two males and fifty-two females. This finding is explained by heavy male recruitment immediately after World War II, encouraged by veterans' allowances.

2. Sex and position

A definite connection was found between the sex of the social worker and the position he occupies in the field of social work. More than 50 per cent of the males in the sample stated their title to be Executive or Other (a category which included such positions as social planner or university teacher). None of these positions involves

1 Using the master lists of hospital social workers, the membership file of the Ontario Association of Professional Social Workers, and data about the sample derived from returns to the questionnaires, and making a few modest assumptions, it is possible to estimate the number of active social workers in Ontario holding the Master of Social Work degree. This estimate is 960. About 70 per cent of these 960 M.S.W.'s belong to the professional association. About 65 per cent of the members of the Ontario Association of Professional Social Workers have the M.S.W. degree.

the delivery of casework services to individuals. Among the female social workers only 20 per cent reported their position to be in the Executive or Other categories.

Conversely, less than 10 per cent of the male, but 33 per cent of the female social workers in the sample reported their position as casework assistant, Caseworker I or Caseworker II. (These are the frontline casework positions carrying the bulk of the casework load, i.e., the most responsibility for the delivery of personal social work services.) This marked difference between males and females as to position within the field of social work (at the .001 significance level) remains unchanged when the connection between sex and position was controlled for age and social work degree.

3. Sex and setting

Connecting sex to setting reveals that only in the setting classified as Other (which comprises the teaching, planning, and federal government settings) were males in the majority among the major settings employing social workers. In the family and children's agencies, the percentage of males was approximately 40 per cent; in the hospital settings the percentage of males was approximately 25 per cent.

4. Social work degree and position

Relating social work degree and position reveals that only 25 per cent of Social Worker I's (assistants and social workers) have the M.S.W.

degree. For the position of Social Worker II through Supervisor inclusive, the percentage with an M.S.W. degree varies between 62 per cent and 74 per cent. Fifty-four per cent of social workers in executive positions have the M.S.W. degree.

5. Settings and position

It will be noted from Table 9 relating setting and position, that almost one-third of the social workers in the sample who give their title are serving in capacities which involve them in little or no direct casework service. These are social workers under the classifications "Director" and "Other" in the sample who occupy executive, social planning, promotional or teaching positions. In addition, the forty-three supervisors and a majority of the forty-four senior social workers and thirty-nine social workers of grade 3, 4 or 5, are in positions which require that much or the majority of their time be spent on administrative and supervisory tasks, severely limiting their opportunity for direct casework services. Thus, two-thirds of the most highly trained social workers in the province are spending the majority of their time in functions that do not involve direct services to clients or patients. It appears that the great bulk of social work services to individuals and families in all settings, although to a somewhat lesser degree in the mental and general hospital settings, are provided by social workers trained on the job in staff development programs under the supervision of

graduate social workers. This finding adds weight to the opinion of those who recommend greater emphasis in the graduate schools of social work in training for supervision and consultation as opposed to frontline casework.

6. Regional Distribution and Setting

In Table 10 it is clear that the only settings that are well-distributed regionally are those which are mainly administered and/or financed by a government department. The role of the provincial government in supporting the social work services available outside the urban centres can be seen in that 70 per cent of the social workers reporting their work place as other than one of the large urban areas specified in the questionnaire are employed in Children's Aid Societies or Ontario mental hospitals. Only 3 per cent of the professionally trained social workers in the non-urban areas are employed in general hospitals.

In Toronto, on the other hand, fully 16 per cent of these qualified social workers are employed in general hospitals.

Career Mobility

Social workers are reputed to have considerable career mobility. In one sense the data substantiates this and in another tends to refute it. Sixty-three per cent of the sample have been working for their present employer for less than five years. An additional 21 per cent

have been working for their present employer between five and ten years, and only 16 per cent for more than ten years.

With respect to mobility between different types of settings, however, the data are significantly different. Fully 65 per cent of the social workers in the sample have worked in only one or two different settings during their careers. An additional 24 per cent have worked in three settings and only 11 per cent of social workers have worked in four or more settings.

In other words, social workers are highly mobile among employers in the same type of setting, but much less so across the settings. This latter finding would tentatively indicate a degree of de facto specialization within social work for most practitioners. The finding is further substantiated when it is considered that the social workers in the sample are generally more highly trained, and therefore might be expected to have greater career mobility than those trained in agency staff development programs specific to a particular setting and agency.

Interprofessional Relationships in the Hospital Settings

1. Frequency of social worker consultation with members of own and other professions in the hospital setting

In the questionnaire we asked social workers how frequently they consulted with others about the treatment of patients, and how satisfying they found these consultations. Consultations with the following

were examined: 1) social work supervisors, 2) psychiatrists, 3) other doctors, 4) psychologists, 5) nurses, 6) other professional social workers, 7) other non-professional social workers.

Table 11 summarizes the data on frequency of consultations with these groups by social workers in the general and psychiatric hospital settings.

2. Satisfaction with consultations

The most striking finding about how satisfying social workers find their consultations with other professionals is this: the likelihood that social workers will find consultations with members of another profession satisfying is closely related to the frequency with which they consult with members of that group. This is brought out most strikingly in the data relating the frequency of consultations with physicians to the degree of satisfaction experienced by social workers (Table 12).

The finding illustrated in Table 12 is consistent with the hypothesis that frequent interaction results in favourable mutual attitudes on the part of the participants. This may have significant implications with respect to the potential for productive collaboration among professions in the health field.

The major alternative hypothesis for interpreting Table 12 is that those social workers who are consulting with physicians (other than psychiatrists) at least once a day about the treatment of a patient or client are those who willingly accept an ancillary position to the physician and are willing to defer to his directives, even when they are prescriptions for social therapy. Under this alternative

hypothesis, when a physician and a medical social worker share the same concept of the social worker's limited role, frequent interaction takes place. When, however, the social worker defines his responsibilities more broadly, and seeks more autonomy in the application of his skills to patients in the hospital settings, the physician will refrain from calling in or consulting with the social worker.

It is difficult, on the basis of this data alone, to determine which of these two hypotheses is correct. Further research in this area is necessary also because of the implications for the possibility of productive collaboration between social work and the medical professions in the health settings.

3. Reasons for satisfaction or dissatisfaction by social workers with consultations

The social workers in the sample were also asked: "What do you find satisfying or unsatisfying about consultations with a) your social work supervisor or supervisors, b) psychiatrists, c) other doctors, d) psychologists?

Respondents were given relatively small space in which to answer and the first "satisfaction" and first "dissatisfaction" only were coded. It is interesting for each of the four groups to note the ratio of satisfactions to dissatisfactions named by the members of the sample. (Table 13).

For social work supervisors, the ratio is 123:31; for psychiatrists, 134:104; for other doctors, 98:114; for psychologists, 94:68. Only in the case of consultations with other doctors are there more social workers who cite at least one dissatisfaction than those who cite at least one satisfaction.

The sources of satisfaction mentioned by the social workers were classified into eight categories:

1) The availability for consultation of members of the other profession.
2) Interest and/or concern by members of the other profession in casework or in the individual patient or client.
3) The judgement or expert knowledge of members of the other profession.
4) the helpfulness of members of the other profession in making concrete decisions.
5) Knowledge or appreciation of, or a clear satisfactory definition of the social worker's role by members of the other professions, or of the other profession's role by the social worker.
6) Presence or absence of status problems or other interpersonal problems between social workers and members of the other profession.
7) Agreement between social workers and members of the other profession over goals or methods of treatment.
8) Other reasons.

The reasons for finding consultations unsatisfying were coded into a set of eight categories, each one the opposite of a corresponding satisfaction. For example, the first category of dissatisfactions was the unavailability for consultations of members of another profession.

Table 16 summarizes the findings on social worker's reaction

to their consultations with their social work supervisor, psychiatrists, other physicians and psychologists. The first interesting thing to note about the table is that for all four groups, social workers more frequently cite access to the expert opinion of the other profession as a reason for satisfaction than they do helpfulness in making concrete decisions.

This finding is most pronounced for psychologists. This might indicate that the psychologists' skills in diagnosis through the application of sophisticated testing techniques is respected as relevant by social workers and regarded as the kind of expert opinion that they could not generate themselves. On the other hand, psychological tests must be carefully interpreted and integrated with other elements in the diagnosis, so that there is less direct connection between the expert opinion and its application in making decisions about diagnosis or treatment plans.

It appears that in consultations with psychiatrists about the treatment of a client or patient, discussion usually centres on a particular problem in diagnosis or treatment, and the social worker often incorporates the interpretation and recommendations of the psychiatrist directly into some of his decisions.

On question of role definition between professions, there is the striking finding that, of all groups, it is only with physicians other than psychiatrists that social workers feel this to be more often a source of dissatisfaction than of satisfaction.

It is noteworthy, however, that in the case of psychiatrists questions of role definition are almost equally a source of both dissatisfaction and satisfaction.

Equally significant is the finding that conflict over goals or methods of treatment between social work and another profession are felt more frequently with psychologists than with any of the other groups.

Social Workers' Perceptions of Coordination and Cooperation among Professions in the Hospital Settings

1. Social Workers were asked the question: "How successfully have coordination and cooperation been achieved among the professions in your setting?" They were asked to select one of the following four response categories: a) successfully, b) partly successfully and partly unsuccessfully, c) unsuccessfully, d) don't know.

In the overall sample, six or 1.9 per cent of the social workers replied they did not know; ninety-seven or 30.5 per cent replied that coordination was successful; 207 or 65.1 per cent replied that it was partly successful and partly unsuccessful; and eight or 2.5 per cent replied that it was unsuccessful.

Of the four major settings, the highest proportion of social workers replying that coordination and cooperation were successful were in the family service agencies and the psychiatric hospital settings. Thirty-eight per cent of the social workers in the family services agencies and 38.7 per cent of social workers in the mental health settings described interprofessional relationships as successful.

2. The social workers were also asked: "What, if any, are the obstacles to more successful coordination and cooperation among the professions in your setting?"

Of the 357 respondents, 105 mentioned no obstacles to more successful coordination and cooperation; eighty-three mentioned one; seventy-one cited two; and ninety-eight named at least three.

The obstacles mentioned by the social workers were coded into the following categories:

1) Lack of time.
2) Lack of planned interaction with other professions on the job.
3) Ignorance of social work functions or resources on the part of other professions OR ignorance of the functions or resources of other professions on the part of social workers.
4) Lack of role definition (of own or another profession).
5) Rigidity of role definition (of own or another profession).
6) Incompetence of members (of own or another profession).
7) Status anxieties of professional rivalries.
8) Different philosophies of or approaches to handling cases between professions.
9) Other

In cases where a respondent had named more than three obstacles, only the first three were included in the count. Table 14 indicates the distribution of first responses and of all three responses among the nine categories.

We can see that there is a tendency for the category most directly indicating underlying anxiety and conflict among the professions (category 7) to be stated as a second or third, rather than the first reason. This was true for all settings except the mental hospital settings. In the mental hospital setting, 18 per cent of social workers named status anxieties or professional rivalries as their first obstacle to more successful coordination and cooperation. Of the total number of reasons given by social workers in the mental hospital setting, however, only 17 per cent were in that category. For social workers in the general hospitals, 11 per cent named status anxieties or professional rivalries as their first obstacle to more successful coordination and cooperation, but that number rose to 17 per cent of the total number of responses.

The distribution of the first and of the total set of responses by social workers in the general and mental hospital settings only to the question on obstacles to coordination among professions is also shown separately in Table 14. The most striking feature here is that the difference in the order of presentation of reasons between social workers in general and mental hospitals is much greater than the difference in the distribution of the total set of obstacles cited among the categories. For instance, 44 per cent of social workers in the general hospitals gave as their first reason "ignorance of one profession by another"

or "lack of role definition of one or another profession" as obstacles to coordination; only 19 per cent of social workers in the mental hospitals listed these obstacles first.

However, of the total number of obstacles cited by social workers in general and mental hospitals, 31 per cent of those listed by social workers in the general hospitals and 22 per cent listed by social workers in the mental hospitals fall into the categories of "ignorance" or "lack of role definition". The difference between the two settings in the proportion of responses falling into these two categories has narrowed from 25 per cent to 9 per cent.

By the same token, 36 per cent of the social workers in the psychiatric hospitals cited reasons of time or lack of contact as the greatest obstacle to coordination, whereas only 22 per cent of social workers in the general hospitals offered these two obstacles as their first response. Of the total number of responses, however, 26 per cent of those offered by social workers in the mental hospitals, and 23 per cent of those offered by social workers in the general hospitals mentioned lack of time for, or planned contact with other professions.

Taken together, these findings indicate that a common set of obstacles to more effective coordination among professions are perceived by social workers in both general and mental hospitals, but that the importance assigned to the obstacles by the social workers

varies between the two settings.

3. A better picture of the opinions of social workers on the obstacles to more successful collaboration among professions in the health settings can be drawn by quoting some representative responses.

We attempted to select a set of responses to the question, "What, in your opinion, are the obstacles to more successful collaboration among the professions in your setting?" in proportion to the number of responses falling into each of the nine categories. Thus this set of quotations from the questionnaires is representative of the comments of all social workers in the health settings:

> A social worker in a mental hospital said, "The obstacles are largely of an objective nature - the large number of people and the hours they work. In fact, the amount of coordination is close to optimum."
>
> Another social worker in a mental hospital said, "Demands on inadequate staff do not give enough time for conferences.
>
> A social worker in a general hospital said, "There is a lack of interdisciplinary conferencing. Coordination and cooperation can be accomplished on a one-to-one discussion basis, but it is time-consuming and places undue responsibility on the social worker."

Some responses which touched on the question of ignorance of one another's functions or lack of clarity and role definition included:

> "There is a lack of understanding of the purpose and function of each profession within the setting and the role they play toward the rehabilitation of the patient. The professions often work in isolation instead of in a coordinated manner." (By a social worker in a mental hospital.)

Another social worker in a general hospital said, "There is lack of understanding of the role of a social worker; inadequate communication between disciplines; and an overlapping of services - particularly in the area of counselling."

Still another social worker in a general hospital said, "A greater degree of cooperation could be achieved if the other professions had more understanding of the role of the social worker. This understanding should be given to other professionals during their training period."

Another in the same setting (general hospital) said, "The main obstacle is ignorance on the part of the medical person (doctor or nurse, or both) regarding the medical social worker and the part she can play on the 'team'."

From a social worker in a general hospital came the response, "There is lack of understanding of the role of the social worker on the part of the medical and nursing staff, and in part, perhaps, a refusal to accept and understand this role. On the other hand, the social worker can be guilty of not accepting and understanding the role of the medical and other professional staff. I do find that progress is being made."

Another medical social worker said, "My specific setting is clinical investigation and provides ideal working relationships between all professions (doctors, nurses, social workers and dietitians). In other parts of the hospital, however, communication seems to break down, partly because of the lack of definition of the social worker's role - also because some of the incompletely trained social workers lack an understanding of interdisciplinary cooperation."

One social worker in a general hospital said that "lack of top level meetings between heads of various departments underlay some of the lack of understanding of one another's role among the professions."

Responses which touched on rigidity of role definition as an obstacle to cooperation included that of a social worker in a general

hospital:

> "lack of training in medical (and some nursing) schools over the social implications of illness..."
>
> Another in the same setting said, "There is lack of teamwork - each department is too inclined to work as a unit instead as part of a whole. Professional jargon makes for poor understanding among the professions. Sometimes there is too little information given in conferences among the professions."

Many of the responses of social workers in both settings dealt with status anxieties or professional rivalries as obstacles to coordination and cooperation among professions:

> One social worker in a mental hospital commented that "The chief obstacle in this hospital is the inability or unwillingness of top administration to accept social work or psychology as professions competent to play a vital role in treatment and in policy planning bearing upon treatment. The result is a lethargic climate clinically and a non-co-ordinated treatment program."
>
> Another in the mental health setting cited "the insecurity of the social work profession". Yet another social worker in a mental hospital remarked, "All these professions are very insecure. Some of the older M.D.'s feel that their area of concern is being invaded. Social workers and psychologists refuse to play an inferior role and are demanding more say-so. (That is, they get aggressive and make the psychiatrists feel threatened.)"
>
> One social worker in a general hospital said that "Some disciplines are unable to accept the professional training of another at an equal level. The social workers still present a threat to some disciplines."

Another social worker in a mental health setting said "Individual idiosyncracies are allowed to create barriers which hinder more complete cooperation. While staff members are intelligent, sensitive and sincerely concerned, they are seldom relaxed with each other. I think certain staff members are excessively defensive about the role of their particular discipline and this has a cumulative effect."

Several responses dealt with different philosophies or approaches to handling cases as obstacles to better coordination and cooperation among professions:

One social worker in a mental hospital said, "Some doctors deny the relevance of social and emotional problems to physical illness."

Another response by a social worker in a mental hospital criticizes the medical model underlying psychiatric treatment: "Our setting is largely operated on the medical model, that is the mental patient is viewed as a 'sick person' just as if he were in a general hospital for surgery. This means that the ward is no more a 'social system' than is a surgical ward.

"The cause of mental illness in many cases is rooted in social difficulties, yet the patient enters an antiseptic, socially sterile ward. Here the patient often regresses socially, even though if noticeable symptoms may disappear through the use of psychothropic drugs."

A social worker in a mental hospital said, "Some of the team members, i.e., nursing staff supervisors, are rather inflexible in their approach to patients and rely upon custodial techniques although they agree verbally with a more permissive approach. In actual practice they remain rigid. This proves very frustrating to both the staff members and patients."

One social worker in a general hospital criticized hospital personnel for "the failure to see the patient and his family as a unit."

Among the responses coded in the "other" category were included some that related to individual traits. For instance, one social worker in a mental hospital setting said:

> "The obstacles are almost purely individual - based on the individual's personality, characteristics, tastes, etc. For example, one psychiatrist who is married to a social worker cannot bear to work with an aggressive social worker."

Other responses coded "other" were a few that mentioned the rigid attitudes of some "old guard" personnel who could not adapt to new concepts of treatment or were "afraid to try new ideas". One social worker in a mental hospital suggested that "social workers are not research-oriented" and that this is an obstacle to inter-professional collaboration.

Finally, coded in the "other" category, was this response from a social worker in a general hospital:

> "In <u>my</u> setting, the only obstacle is lack of skill in using the teamwork method - my own as well as the other profession's. I would suggest a workshop conference to practice communication. It <u>is</u> a problem and the other professions should improve as well as the social work profession."

4. The stakes in interprofessional collaboration

At this point, and in conclusion, I would like to quote from a letter attached to the questionnaire by a social worker in the Children's Aid Society. As well, I shall recount an incident at the first inter-professional student-faculty seminar sponsored by the University of

Toronto School of Social Work around the neglect and abuse of children.

First, the letter:

> I am convinced that everyone who works in the helping and healing professions today requires a basic education in psychology and sociology and in the understanding of the manifestations of socio-cultural and psychosocial phenomena in the whole range of human stress and disturbance. I believe that such a common basis in professional education will go a long way in removing some of the obstacles presently met with in inter-disciplinary cooperation. To cite an example: The orthopaedic surgeon recognizes his need of physiotherapy because he sees the re-education of muscles as an integral part of his treatment plan. Often he does not see the need of social work services simply because he has not been trained to perceive the psycho-social factors involved in providing the kind of familial and community environment in which his treatment plan can be effectively carried out, and its goals realized.
>
> Many take a very narrow view that repair of physical damage and restoration of physical functions is all that is required, although some, because of individual qualities, take a broader view.
>
> I also notice that medical professionals have great difficulty in accepting what is to social workers a basic assumption in practice - that is, the capacity of people to change. This is a very basic area of difference of opinion when we try to work together and needs to be looked at.
>
> ...I believe that sometimes people are being rejected for treatment and not referred to what may be a more appropriate source of help because their initial motivation for help is not strong enough to enable them to use the help in the way it is offered. I firmly believe that we all must, in the helping and healing professions, take responsibility for offering the kind of services that people need in such a way as to facilitate their using it. In psychiatric settings

this does not seem to be a concern, and people seem to be written off as unhelpable who, in my personal experience, have responded well to certain kinds of health care, if offered in a way that makes sense to them.

The present situation in respect to mental health services in this community is so serious that it is hard to write about it calmly...I find that social histories may never reach the social service department in the local Ontario Hospital, and that Canadian Mental Health Association volunteers become discouraged because their offers of such services as friendly visiting are just ignored.

I do recognize that such problems as I have cited are never one-sided. I sincerely hope that one result of this tudy in which you are engaged will be to show us all where we fall down in inter-professional collaboration, and to indicate what social workers need to do to promote better cooperative approaches to the job we all want to do well."

I now quote from a report of the Inter-professional Student-Faculty Seminar on the Neglect and Abuse of Children, mentioned above. This was held in 1962.

Nine different professional divisions participated. No-one who attended the opening plenary session will ever forget the experience. A paediatrician, the first of four speakers, used coloured slides. His first showed the head of a small baby with a large, ugly hole chewed out by a rat. Reconstruction of the case revealed that the rat had done its gruesome work while the child lay in bed between its parents who were in a drunken stupor.

Before the end of the day a strong case had been made for inter-professional collaboration in the healing, teaching and helping professions.[2]

2. University of Toronto School of Social Work, Fiftieth Anniversary, School of Social Work, 1964, pp. 5-7.

Chapter 5

CONCLUSIONS

Social Service Departments in General Hospitals

In the light of the observations and findings considered in the earlier parts of this report and subject to the reservations noted elsewhere, the following are a set of proposed staff:bed ratios for social service departments in Ontario general hospitals:

a) Teaching hospitals in large cities - one social worker per 100 beds.
b) Other large hospitals should approximate this standard in relation to the volume of their out-patient services and the size of their public wards.
c) All hospitals in large cities with more than 150 beds should establish a social work department with at least one full-time social worker.
d) In smaller cities and rural areas, hospitals with more than 200 beds should establish a social work department with at least one full-time social worker.

Experiments with alternative ways of providing a full range of social services to smaller hospitals in the large cities and to hospitals in rural areas should be supported by the Ontario Hospital Services Commission.

Three main alternatives to be investigated and demonstrated are

a) Sharing arrangements in a large city between a large hospital and several smaller hospitals. The smaller hospitals would establish social service departments staffed with social service workers educated at the undergraduate level or in the nursing profession. The smaller hospitals would contract with one or more graduate social workers in a large hospital to serve as consultant.
b) Smaller hospitals might utilize the services of a graduate social worker wishing to work on a part-time basis.
c) Local or regional health departments or welfare organizations might employ a graduate social worker as a consultant to work with public health nurses or nurse caseworkers who are providing hospital or home care.

The Ontario Hospital Services Commission should establish the position of adviser in social work, with the functions of

a) consulting with hospitals intending to establish social service departments.
b) assisting smaller hospitals in staff recruitment.
c) supporting research and development projects in staff development for medical social work in the general hospitals.
d) administering bursaries for social workers in medical settings trained on the job, who have the capacity and the desire to attain professional qualifications or for social workers in undergraduate or vocational programs who want practical experience in the hospital setting. These bursaries should be financed through the federal-provincial mental health training grants program, or a similar program.

The Ontario Hospital Services Commission in conjunction with the medical social work section of the Ontario Hospital Association should sponsor workshops for hospital administrators on medical social work. These workshops would review the experience of

hospital administrators in utilizing social work personnel with different qualifications; with various methods of organizing social services; and with methods of coordinating the services of social workers with the services of other professionals in the hospital.

Full and early consideration should be given by social work educators and practitioners in the medical field to the merits of a post-Master's year of internship for social workers intending to practise in general hospitals. The program would focus equally on clinical experience and academic content. The faculty would be drawn from both the medical and social work disciplines. Present developments in social work education make it likely that in the foreseeable future most entrants into the graduate schools of social work will have had some formal training in social work at the college level. As well, most social workers will have had some academic preparation in social work at least at the community college level. These developments appear to make it possible and desirable for some professional social workers to increase their specialized knowledge and skills in a limited area of practice, without sacrificing the broad community and humanitarian viewpoint of their profession.

It is believed likely that the range of services that the professional social worker will be called on to provide in the hospital setting will be increased if the knowledge relevant to the practice of social work in a medical setting gained in a generic social work program is

supplemented during this specialized period of internship. Increased knowledge of the emotional and social ramifications of illness in general, and of physiology as well as the emotional and social problems connected with those diseases and categories of patient most commonly associated with social pathology, will make collaboration with physicians more fruitful.

Public Health Nursing and Social Work

Schools of public health hygiene and nursing should carefully study the role of the public health nurse in community health programs. It is likely that such a study will indicate the extension of the basic training of public health nurses to include sufficient social work background, particularly in casework study, as part of their multiple generalized duties, so that they will be competent to undertake the less technical social work.

In communities with extensive outpatient and home-care programs a social worker with high qualifications should be appointed as a consultant to the local department(s) of health to work with public health nurse caseworkers.

Careful attention to defining and delineating the appropriate role and scope of responsibilities of the medical social worker and to identifying more sharply the special contribution which the medical social worker can make, will serve to clarify working relationships between her and the public health nurse and nurse caseworker.

Measures to Increase the Extent and Effectiveness of Collaboration Between Specialists in the Clinical and Social Viewpoints Working in Hospitals

Schools of medicine in Ontario should be encouraged to make joint appointments from the staff of the School of Social Work to the Faculty of Medicine.

The medical school curricula should include lectures and seminars in the social and emotional aspects of clinical conditions; in the viewpoint, skills, and functions of social workers; and in the processes of collaboration with social workers and other allied professions working in the hospital.

Joint seminars should be held in teaching hospitals between medical internes and residents, and graduate social work internes or caseworkers around selected topics in social medicine. Both medical and social work faculties should instruct their students in the emotional and social ramifications both of illness in general and of special conditions and/or categories of patients with which social pathology is most commonly associated.

General hospitals should be encouraged to include qualified social workers in clinic conferences and on ward rounds.

Hospitals should be encouraged to experiment with various methods of collaboration between social work and the other professions involved in the care of ward as well as private patients in hospitals.

Medical students at all levels (undergraduate, interneship, and residency) should be encouraged to make field visits to appropriate social service agencies.

A broad program of theoretical and applied research in social medicine should be undertaken in a new health sciences centre or elsewhere. One of the early problems that should be investigated is the consequence of hospital function and interprofessional relationships for the functions of social work in the hospital setting. It may be found that the function of the general hospital is largely to treat medical conditions at an acute stage, for a short time, with the most powerful treatment techniques available, whereas the goals of professional social workers are to treat social and emotional problems over a typically longer period of time, with less powerful techniques. If so, it might be concluded that attention to the emotional and complex social problems of patients or their families by social workers, however skilled, during the period of hospitalization, is incompatible with the main function of the hospital.

Or it may be found that were it not for interprofessional rivalries, the skilled social worker could play a more important role in preparing patients for surgery or helping them to adjust to the social implications of a chronic condition.

In any event, the issues should be frankly confronted.

Cooperation Among Social Work Agencies

Administrators of social work agencies and departments in both medical and supportive settings should immediately convene a series of conferences on the potentials and problems of interagency cooperation in the provision of coordinated services to multi-problem families. Problems of coordination are growing more important with the continued development of specialized social work services in a variety of new settings and the increased emphasis on intensive services in several settings previously providing only brief services. Lack of proper coordination may result in the duplication of services by different settings and of subjecting multi-problem families to conflicting social work treatment plans. One urgent area for collaboration is among the agencies providing services to children (school, children's aid, juvenile court).

Utilization of Volunteer Services

Social work educators and administrators should take the initiative in promoting the expansion of volunteer services to play a role in the preventive and rehabilitative phases of health care. Professionally trained social workers should be instructed in the possibilities and methods of utilizing volunteer services in these areas (e.g., education in venereal disease control and in the availability of community mental health services, friendly visiting to geriatric or mental patients).

APPENDIX

Note: All the tables in the Appendix are compiled from returns to the Committee on the Healing Arts questionnaire surveys except as indicated.

ONTARIO 1966

THE FIELD OF SOCIAL WORK			THE FIELD OF HEALTH[1]		
Field of Practice	Number practising	% of Total	Profession or Occupation	Number Practising	% of Total
All programs	3,485	100	Total	57,734	100
Public Assistance	645	18.5	Physicians	8,739	15.1
Other Family Services	180	5.2	Dentists	2,505	4.4
Children's Aid	892	25.6	Nurses	35,430	61.4
Rehabilitation: (Health, Vocational, Reform)	150	4.3	Pharmacists	4,153	7.2
Other services to Offenders	278	8.0	Selected Health Occupations:		
HEALTH:			Medical Record Librarians	207	0.4
Psychiatric Social Workers (including assistants)	225	6.4	Dietitians	1,560	2.7
Child Care Workers (for emotionally disturbed children)	331	9.5	Laboratory Technicians	1,466	2.6
Medical Social Workers (In general hospitals)	160	4.6	Radiological Technicians	1,861	3.1
(Total Health)	(716)	(20.5)	Physiotherapists	831	1.4
Other (including schools, group services, community organizations, & teaching social work)	624	17.9	Occupational Therapists	266	0.5
			Social Workers: Medical	160	
			Psychiatric	225	
			Child Care Workers	331	
			(Sub-total)	(716)	1.2

Source: The inventory of social workers is compiled from several sources. Figures for social workers in the Family Service, Child Care and Other fields are estimates projected from returns to the Administrators Questionnaire. The data for Children's Aid, Rehabilitation, Offenders and Public Assistance were provided by the personnel branches of the Departments of Social and Family Services and Reform Institutions.

The estimate of medical social workers is made from the Ontario Hospital Association master membership file adjusted to the returns by Ontario Hospitals to the Ontario Hospital Services Commission personnel form. The figure for Mental Health Institutions is drawn from the Department of Health personnel file and the Committee's questionnaire to Social Work Administrators.

The inventory of health personnel is drawn from R. D. Fraser, Selected Economic Aspects of the Health Care Sector in Ontario, Committee on the Healing Arts, Queen's Printer, Toronto, 1970, p. 17, Table 2.7 and Appendix 1.

THE FIELD OF SOCIAL WORK

Field of Practice	TOTAL				NO. WITH GRADUATE EDUCATION			
	1950	1960	% change 1950-1960	% of Total	1950	1960	% change 1950-1960	% of Total
All programs	74,240	105,351	41.9		11,958	20,017	73.2	
Public Assistance	30,110	35,175	16.8	33.4	1,204	1,005	12.4	5.3
Other Family Services	4,749	8,556	80.2	8.1	1,995	3,080	54.4	15.4
Child Welfare Work	12,397	23,900	92.8	22.7	2,945	5,797	96.8	29.0
Rehabilitation Services	1,756	2,538	44.5	2.4	140	431	207.9	2.2
Ind. Social Work	2,804	3,430	22.3	3.3	1,374	1,886	37.3	9.4
In hospital	n.a.	2,646	-	2.6	n.a.	1,455	-	7.3
Outside hospital	n.a.	784	-	.7	n.a.	431	-	2.1
Psychiatric Social Work	2,253	5,141	129.5	4.9	1,456	3,717	155.3	18.6
In hospital	1,182	2,917	149.3	2.8	567	1,916	237.9	9.6
Outside Hospital	1,071	2,224	107.7	2.1	889	1,801	102.6	9.0
Services to adult Offenders	2,298	5,254	128.6	5.0	184	420	128.3	2.1
Services to aging	652	813	24.7	.9	39	81	107.7	.4
Group Services	8,764	10,957	23.9	10.3	964	1,086	12.7	5.4
Community services	2,675	7,647	185.9	7.3	586	1,453	148.0	7.3
Teaching Social Work	518	890	71.8	.8	383	676	76.5	3.4
Other, unknown	5,264	1,120	-	1.1	760	385	-	1.5

THE FIELD OF HEALTH

Health Occupations	1950	1960	Health Occupations	1950	1960
All occupations	1,531,000	2,176,000	Social workers, medical and psychiatric	6,200	11,700
Medical occupations	608,500	817,200	Therapists, occupational	2,000	8,000
Physicians (M.D)	220,000	260,500	Therapists, physical	4,600	9,000
Administrators, hospital & other	8,600	12,000	Therapists, speech and hearing	1,500	5,400
Chiropractors	20,000	25,000	Dentists	87,200	101,900
Dietitians and Nutritionists	22,000	26,000	Dental Hygienists	7,000	12,500
Medical Secretaries and Office Assistants	70,000	90,000	Dental Assistants, dentist's Office	55,200	82,500
Medical Laboratory Technologist/technicians	30,000	65,000	Dental Laboratory technicians	21,000	25,000
Med. record librarians	4,000	8,000	Professional Nurses	375,000	504,000
Med. record technicians	8,000	20,000	Practical nurses	137,000	206,000
Med. x-ray technologists/technicians	30,600	70,000	Aides, orderlies & attendants	221,000	375,000
Opticians & optical laboratory mechanics	19,200	20,300	Homemakers, home health aides	500	2,300
Optometrists	17,800	17,300	Sanitary & health related engineers	6,000	8,000
Pharmacists	101,100	117,000	Sanitarians	5,000	11,000
Podiatrists	7,100	7,600	Radiological health specialists, including health physicists	-	2,000
Osteopaths	12,700	14,300	Industrial hygienists	-	1,300
Psychologists, clinical & other	3,000	8,000	Health research occ. in biological sciences, etc.	7,000	28,000
Rehabilitation Counsellors	1,500	3,000			

Source: Data on Social Work from Departmental Task Force on Social Work, Education and Manpower, U. S. Department of Health, Education and Welfare, Closing the Gap in Social Manpower, Washington D. C., 1965, p. 86.
Data on Health Occupations from Report of the Task Force on Health Manpower, National Commission on Community Health Services, Health Manpower, Action to Meet Community Needs, Public Affairs Press, Washington D. C., 1967, p. 37.

Note: In addition, no figures or reliable estimates for the following employers of social workers were available:
Community organizations (e.g, Y.M.C.(H)A., Settlement Houses, Half-way Houses, Private Day Nurseries)
Social Planning Agencies
Local Health Departments and General Hospitals employing public health nurses doing social casework in the hospital or community

If the table (3) is considered from the point of view of all social work services provided, the large number of active volunteer workers could also be included.

The sources for this table are essentially the same as for Table 1.

EMPLOYER	Sub-total	Total	SOCIAL WORK			Nursing RN, PHN RNA	Lib. Arts College BA	Other (mostly Sr. or Jr. matriculation	Unknown
			M.S.W.	B.S.W. or Diploma	Certificate (OCAAT)				
Dept. of Social and Family Services: Welfare Field Worker Officer	263								263
Rehabilitation Worker (vocational)	35	298					35		
Dept. of Reform Institutions & Attorney-General's Office:									
Probation Officers	241								241
Welfare Field Workers	37								37
Rehabilitation Officers	78	356							78
Dept. of Health: (mostly in									
Social Workers) Ontario	128		75	40			13		
Social Work Assts.) Hospitals)	64								64
Child Welfare Supervisors	13								13
Child Care Workers	91								91
Rehabilitation Officers	33	329							33
General Hospitals (including Psychiatric facilities)		143	46	30		27	27	7	6
Special Hospitals or Societies:									
Clarke Institute of Psychiatry	18		18						
Alcoholic & Drug Addiction Research Foundation	24		18	6					
Ontario Crippled Children's Society	26	68	5			21			
Municipal Depts. of Public Welfare:									
Toronto	132								132
Other (estimate)	250	382							250
Children's Aid Societies		896	118	68		107	289	199	115
Private Children's Residential Institutions (estimate)		125							125
Family Service Agencies		180	132	15		5	15	13	
Boards of Education		50	30	10			10		
Grand Total	2,	827							

Category of Hospital	Number of Hospitals	Number of Hospitals with Social Work Departments	Number of Full-time Social Workers Employed	Number of Beds	Social Worker: Bed Ratio
A (14 of 18 hospitals in this category have more than 500 beds)	18	16	78	13,023	1:167
B and C					
more than 400 beds	6	5	7	3,203	1:458
200-400 beds	41	16	21	11,963	1:569
under 200 beds	109	3	4	9,139	1:2,284
Convalescent and Chronic Hospitals (these hospitals vary greatly in size)	13	8	13	4,975	1:375

TABLE 5 DISTRIBUTION OF SOCIAL WORKERS BY SEX, ONTARIO, 1967

Sex	Number	Percentage
Male	116	33.2
Female	233	66.8
Total	349	100.0

TABLE 6 DISTRIBUTION OF SOCIAL WORKERS BY AGE, ONTARIO, 1967

Age	Number	Percentage
Under 30	48	13.9
30-39	87	25.1
40-49	101	29.2
50-59	82	23.7
60 and over	28	8.1
Total	346	100.0

TABLE 7 DISTRIBUTION OF SOCIAL WORKERS BY LEVEL OF TRAINING, ONTARIO, 1967

Qualifications for Social Work	Number	Percentage
Master of Social Work (M.S.W.)	202	58.0
Bachelor of Social Work (B.S.W.)	45	12.9
Diploma or Certificate in Social Work	63	18.2
No Social Work Degree	38	10.9
Total	348	100.0

Note: Many of the Social Work Diplomas and Certificates are equivalent to M.S.W.; therefore the M.S.W. and equivalent may be as high as 70%.

TABLE 8 ORIGIN OF SOCIAL WORK DEGREE/DIPLOMA

Where Educated (Formal education in Social Work only)	Number	Percentage
Toronto	168	53.3
Ottawa	36	11.4
Montreal	18	5.7
Rest of Canada	39	12.4
United States	27	8.6
Great Britain	18	5.7
Rest of the world	9	2.9
Total	315	100.0

TABLE 9 DISTRIBUTION OF SOCIAL WORKERS BY WORK TITLE, ONTARIO, 1967

Setting	FORMAL							
	Case-aide		Soc. Wkr. I		Soc. Wkr. II		Soc. Wkr. III, IV, V	
	No.	%	No.	%	No.	%	No.	%
Voluntary family or child agencies	1	1.9	1	1.9	7	13.3	3	5.7
Children's Aid Societies	0	0.0	0	0.0	2	3.6	9	16.4
Public Welfare Agencies	0	0.0	0	0.0	0	0.0	2	22.2
General hospitals (social service depts. only)	3	5.3	5	8.8	6	10.5	11	19.3
Mental health facilities (including psychiatric dept. or div. in gen. hosps.)	1	1.0	19	19.6	31	32.0	13	13.4
Correctional institutes or departments							1	12.5
Board of Education					1	11.1		
Community organizations (e.g. YMC(H)A)	2	13.4			1	6.7		
Other (planning board, promotions, schools of social work, etc.)								
Total	7	21	25	7.4	48	14.2	39	11.6

1. Includes teachers, consultants and planners.

SETTING AND FORMAL

ITLE enior oc. Wkr.		Soc. Wkr. Grade unspecified		Supervisor		Director		Other 1		Total	Title not specified	Grand Total
o.	%	No.	%	No.	%	No.	%	No.	%			
6	11.4	3	5.7	12	22.8	17	32.3	2	3.8	52	2	54
7	12.7	1	1.8	24	43.6	11	20.0	1	1.8	55	2	57
2	22.2	0	0.0	0	0.0	4	44.4	1	11.1	9	0	9
5	8.8	13	22.8	5	8.8	9	15.9	0	0.0	57	9	66
8	18.6	4	4.1	1	1.0	7	7.2	3	3.1	97	4	101
1	12.5					6	75.0			8	1	9
3	33.3	2	22.2	1	11.1			2	22.2	9	0	9
1	6.7	2	13.4			7	46.7	1	6.7	14	1	15
1	2.8	2	5.6			14	38.9	19	52.8	36	1	37
4	13.1	27	8.0	43	12.8	75	22.3	29	8.6	337	20	357

TABLE 10 REGIONAL DISTRIBUTION OF SOCIAL WORKERS BY WORK SETTING, ONTARIO, 1967

Location	Vol. Family & Child Agency		Children's Aid. Soc.		General Hospital		Mental or Psychiatric Hosp.		Public Welfare		Correction		School		Other vol. Agencies		Other Settings		Total
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	
Toronto	30	16.5	27	14.8	37	20.3	43	73.6	5	2.7	3	1.6	8	4.4	12	6.6	17	9.3	182
Ottawa	7		1		9		4		5		2						11		39
Hamilton	1		7		3		4				1						4		20
London	2		3		5		10								1		1		22
Windsor	6		4		1						1				1				13
Rest of Ontario	8	10.8	14	18.9	7	9.5	38	51.4		-	2	2.7	1	1.4		-	4	5.4	74
Total	54		56		62		99		10		9		9		14		37		350

TABLE 11 FREQUENCY OF CONSULTATIONS BY GENERAL AND MENTAL HOSPITALS

Frequency of consultation		Psychiatrists		Other Physicians		Psychologists	
		Gen.	Ment.	Gen.	Ment.	Gen.	Ment.
at least once/day	No.	3	31	19	10	0	10
	%	5.9	33.3	34.6	12.4	0.0	11.5
several times/week	No.	9	34	22	15	6	22
	%	17.6	36.6	40.0	18.5	12.0	25.3
several times/month	No.	8	17	10	18	9	26
	%	15.7	18.3	18.2	22.2	18.0	29.9
several times/year	No.	22	6	2	15	13	12
	%	43.2	6.4	3.6	18.5	26.0	13.8
rarely or never	No.	9	5	2	23	22	17
	%	17.6	5.4	3.6	28.4	44.0	19.5
Total	No.	51	93	55	81	50	87
	%	100	100	100	100	100	100

SOCIAL WORKERS IN THE
WITH OTHER GROUPS

Other prof. Social Workers		Soc. Work Supervisors		Nurses		Other Non-Prof. Social Workers	
Gen.	Ment.	Gen.	Ment.	Gen.	Ment.	Gen.	Ment.
8	13	3	3	26	26	7	9
14.8	15.0	6.7	4.5	47.3	30.2	13.5	12.2
11	19	4	10	18	24	13	12
20.4	21.8	8.9	14.9	32.7	27.9	25.0	16.2
27	35	18	28	4	16	12	20
50.0	40.2	40.0	41.8	7.3	18.6	23.1	27.0
4	11	9	6	3	4	6	14
7.4	12.6	20.0	9.0	5.4	4.7	11.5	18.9
4	9	11	20	4	16	14	19
7.4	10.4	24.4	29.8	7.3	18.6	26.9	25.7
54	87	45	67	55	86	52	74
100	100	100	100	100	100	100	100

TABLE 12 . DEGREE OF SATISFACTION WITH PHYSICIANS' CONSULTATIONS BY FREQUENCY OF CONSULTATION

Frequency of Consultation with doctors (other than psychiatrists)	DEGREE OF SATISFACTION									
	Satisfied		Somewhat unsatisfied		Unsatisfied		No opinion		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
At least once/week	25	75.8	7	21.2	1	3.0	0	0.0	33	13.2
Several times/week	28	62.2	16	35.6	1	2.2	0	0.0	45	18.0
Several times/month	24	46.2	22	42.3	6	11.5	0	0.0	52	20.8
Several times/year	27	34.2	41	51.9	6	7.6	5	6.3	79	31.6
Rarely or never	8	19.5	7	17.1	5	12.2	21	51.2	41	16.4
Total	112	44.8	93	37.2	19	7.6	26	10.4	250	100.0

WITH OTHER PROFESSIONALS SATISFYING OR DISSATISFYING (ALL SETTINGS COMBINED)

REASON	GROUP CONSULTED							
	Social Work Supervisors		Psychiatrists		All other Doctors		Psychologists	
	Satis.	Dissatis.	Satis.	Dissatis.	Satis.	Dissatis.	Satis.	Dissatis.
The availability for consultation of members of the other profession	5	6	6	24	3	15	3	8
Interest and/or concern by members of the other profession in casework or in the individual patient or client	4	4	10	2	14	12	5	1
The judgement or expert knowledge of members of the other profession	39	3	41	19	27	16	36	14
The helpfulness of members of the other profession in making concrete decisions	26	5	34	14	15	5	17	5
Knowledge or appreciation of, or a clear satisfactory definition of, the social worker's role by members of the other professions, or of another profession's role by the social worker	18	4	18	17	19	35	16	9
Presence or absence of status problems or other interpersonal problems between social workers and members of the other profession	14	2	15	9	10	10	10	9
Agreement between social workers and members of other professions over goals or methods of treatment	15	3	8	8	7	8	5	13
Other reasons	2	4	2	11	3	13	2	9
Total	123	31	134	104	98	114	94	69

TABLE 14 OBSTACLES TO BETTER COORDINATION AND COOPERATION AMONG THE PROFESSIONS IN HEALTH SETTINGS AS PERCEIVED BY SOCIAL WORKERS

	CATEGORY OF OBSTACLE	All Settings				General Hospitals				Mental Hospitals			
		First Response		All Obstacles		First Response		All Obstacles		First Response		All Obstacles	
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
1	Lack of time	29	12	53	10	3	7	9	10	12	18	19	13
2	Lack of planned interaction with other professions on the job	35	14	65	12	7	15	12	13	12	18	19	13
3	Ignorance of social work functions or resources on the part of other professions or ignorance of the functions or resources of other professions on part of social workers	56	22	96	18	10	22	17	18	8	12	20	14
4	Lack of role definition (of own or another profession)	40	16	71	14	9	20	12	13	5	7	12	8
5	Rigidity of role definition (of own or another profession)	15	6	34	7	4	9	7	8	4	6	16	11
6	Incompetence of members (of own or another profession)	9	3.5	24	5	2	4	6	6	4	6	9	6
7	Status anxieties of professional rivalries	35	14	94	18	5	11	16	17	12	18	27	17
8	Different philosophies of or approaches to handling cases between professions	9	3.5	30	6	1	2	3	3	3	4	7	5
9	Other	23	9	54	10	5	11	11	12	8	12	20	13
	Total	251	100	521	100	46	100	93	100	68	100	149	100

QUESTIONNAIRES USED IN SURVEY OF SOCIAL WORKERS AND SOCIAL WORK AGENCIES, SUMMER 1967

SURVEY FOR THE ONTARIO COMMITTEE ON THE HEALING ARTS

INSTRUCTIONS: Please answer each question, either by placing a mark inside the brackets or by circling the number of the correct response or that which most closely reflects your opinion. Where response categories are not provided, please answer as specifically as possible. To make this a confidential survey, you are asked NOT to write your name on the questionnaire.

1. Are you: ( ) Male?
( ) Female?

2. In which age group are you?
( ) 29 or younger
( ) 30 to 39
( ) 40 to 49
( ) 50 to 59
( ) 60 to 69
( ) 70 or over

3. How many years have you practised your profession?
( ) less than one year
( ) one or two years
( ) 3 to 5 years
( ) 6 to 10 years
( ) 11 to 15 years
( ) 16 to 20 years
( ) 21 to 25 years
( ) over 25 years

4. How many years have you practised in Ontario?
( ) less than one year
( ) one or two years
( ) 3 to 5 years
( ) 6 to 10 years
( ) 11 to 15 years
( ) 16 to 20 years
( ) 21 to 25 years
( ) over 25 years

5. What formal degrees or certificates (e.g. MSW, BSW, diploma) do you have in social work?

6. Where did you receive your professional education?

7. In what city or town do you work?

8. In what type of setting do you work now?
( ) voluntary family or child agency
( ) public family or child agency
( ) public welfare agency
( ) general hospital (social service department)
( ) mental health facility (including psychiatric department or clinic in a general hospital)
( ) other (please specify)

9. What is your formal title?
(Caseworker I, II, III, etc.)

10. Please mark the settings in which you have worked at some time during your career:
( ) voluntary family or child agency
( ) public family or child agency
( ) public welfare agency
( ) general hospital (social service department)
( ) mental health facility (including psychiatric department of clinic in a general hospital)
( ) other (please specify)

11. The longest interruption in your career was:
( ) less than one year
( ) one or two years
( ) 3 to 5 years
( ) 6 to 10 years
( ) 11 to 15 years
( ) over 15 years

12. How many years have you practised with your present employer?
( ) less than one year
( ) one or two years
( ) 3 to 5 years
( ) 6 to 10 years
( ) 11 to 15 years
( ) 16 to 20 years
( ) 21 to 25 years
( ) over 25 years

3. In an average week, approximately how many hours do you spend in each of the following areas of work?

a) intake and/or assessment interviews ☐
b) interviews where patient or client is present (ongoing cases) ☐
c) interviews with members of a patient's or client's family only (ongoing cases) ☐
d) securing assistance in the provision of medical needs (e.g., dentures, glasses) ☐
e) securing assistance with other environmental problems ☐
f) discharge planning ☐
g) follow-up services to discharged patients or clients ☐
h) records, letters, reports ☐
i) meetings, conferences and consultations ☐
j) teaching and supervising ☐
k) work with groups (patients or clients, relatives, etc.) ☐
l) community organization ☐
m) other major areas of work (please specify)

B. i. Determining the treatment or service plan for the client or patient:

( ) all or most responsibility
( ) about equal responsibility
( ) little or no responsibility

ii. Determining the treatment or service plan for the client or patient's family:

( ) all or most responsibility
( ) about equal responsibility
( ) little or no responsibility

C. i. Carrying out the treatment or service plan for the client or patient:

( ) all or most responsibility
( ) about equal responsibility
( ) little or no responsibility

ii. Carrying out the treatment or service plan for the client or patient's family:

( ) all or most responsibility
( ) about equal responsibility
( ) little or no responsibility

. How much responsibility do you ordinarily have in performing the following tasks? NOTE: Responsibility may be shared with a social work supervisor or member of the medical profession.

A. i. Making the psycho-social diagnosis of the client or patient:

( ) all or most responsibility
( ) about equal responsibility
( ) little or no responsibility

ii. Making the psycho-social diagnosis of the client or patient's family:

( ) all or most responsibility
( ) about equal responsibility
( ) little or no responsibility

15. How frequently do you perform tasks which could be done by someone with less training?

( ) frequently
( ) occasionally
( ) rarely or never

16. How frequently are you asked to perform tasks for which you do not feel fully qualified?

( ) frequently
( ) occasionally
( ) rarely or never

17. a) Do you think that professional social workers should do some of the work now done by members of the medical profession?

( ) Yes ( ) No ( ) No opinion

b) What specific things do you have in mind?

---

18. How often does the primary focus of service in your caseload involve the following: (Please circle the number of your response).

KEY: OFTEN 1 SOMETIMES 2 RARELY or NEVER 3

illegitimate pregnancy	1	2	3
family separation (e.g. widowhood, desertion, child leaving home, etc.)	1	2	3
understanding and adjustment to immediate health crisis (admission to hospital, operation, etc.)	1	2	3
understanding and adjustment to chronic illness (diabetes, senility, mental retardation, chronic schizophrenia, etc.)	1	2	3
preparation and encouragement to follow treatment	1	2	3
management of terminal illness	1	2	3
parent-child relationships	1	2	3
marital problems	1	2	3
individual problems of adjustment related to stage of life (old age and retirement, adolescense and rebellion, etc.)	1	2	3

other frequently occurring situations (please list)

_____ _____

_____ _____

On what grounds do you recommend referral of a patient or client to psychiatric treatment?

21. a) How successfully have co-ordination and co-operation been achieved among the professions in your setting?

( ) successfully
( ) partly successfully and partly unsuccessfully
( ) unsuccessfully
( ) don't know

b) What, if any, are the obstacles to more successful co-ordination and co-operation among the professions in your setting? Please elaborate:

In your opinion, on what grounds do doctors refer a patient to a social worker?

2. A. How frequently do you consult about treatment of a client or patient with each of the following:

KEY:	At Least Once A Day	Several Times A Week	Several Times A Month	Several Times A Year	Rarely or Never
	1	2	3	4	5

a) Social Work Supervisor(s)	1	2	3	4	5	e) Nurses	1	2	3	4	5
b) Psychiatrists	1	2	3	4	5	f) Other Professional Social Workers	1	2	3	4	5
c) Other Doctors	1	2	3	4	5	g) Other Non-professional Social Workers	1	2	3	4	5
d) Psychologists	1	2	3	4	5						

B. How satisfying do you usually find consultations about the treatment of clients or patients with the groups in 22 A.?

KEY:	Satisfying	Somewhat Unsatisfying	Unsatisfying	No Opinion
	1	2	3	4

a) Social Work Supervisor(s)	1	2	3	4	e) Nurses	1	2	3	4
b) Psychiatrists	1	2	3	4	f) Other Professional Social Workers	1	2	3	4
c) Other Doctors	1	2	3	4	g) Other Non-professional Social Workers	1	2	3	4
d) Psychologists	1	2	3	4					

C. What do you find satisfying or unsatisfying about consultations with:

a) Your Social Work Supervisor(s)

b) Psychiatrists

c) other Doctors

d) Psychologists

3. Have you taken any formal courses relevant to your work since becoming a professional social worker?

( ) Yes
( ) No

4. Please list the courses and the organizations offering them.

Course	Organization
1.	
2.	

25. For the practice of social work in your setting, would you benefit now from additional formal courses in the physical or mental health field?

( ) Yes
( ) No
( ) No opinion

6. If the answer to Question No. 25 is YES:

What areas would these courses cover?

7. Do you think that social workers in the mental health field should receive

a) specialized professional education and be registered as "psychiatric social workers"?

( ) Yes ( ) No ( ) No opinion

b) Why?

8. Do you think that social workers in the general medical field should receive

a) specialized professional education and be registered as "medical social workers"?

( ) Yes ( ) No ( ) No opinion

b) Why?

29. How satisfied are you with the standards that are prescribed for your professional schools, e.g., regarding entrance requirements, curriculum?

( ) Satisfied
( ) Somewhat Satisfied
( ) Dissatisfied

---

30. Please list any changes you recommend in the standards prescribed for your professional schools:

---

31. Are you currently a member of the Ontario Association of Professional Social Workers?

( ) Yes ( ) No

---

32. How frequently do you attend the meetings or conferences of the associations in your profession?

( ) never attend
( ) very rarely
( ) every few years
( ) about once a year
( ) more than once a year

---

33. In the past year, have you given talks or led discussions concerning your profession in groups within the community?

( ) Yes (How many? _____)
( ) No

---

34. In the past three years, have you published articles -

a) on a clinical or research topic?

( ) Yes (How many? _____)
( ) No

b) on a topic concerning your profession?

( ) Yes (How many? _____)
( ) No

---

35. Is there any behaviour or activity among members of your profession or related professions which is presently unregulated but which you believe should be regulated by law?

( ) Yes
( ) No

If "YES", please specify:

---

36. It is known that in all professions there are some members who engage in professional behaviour which is disapproved of by their colleagues. Please list any behaviour which is disapproved of by your profession that has come to your attention in the past year or two:

7. How satisfied are you with each of the following activities of your professional associations:

	Satisfied	Somewhat Satisfied	Dissatisfied	Don't Know
a) Defining and clarifying ethical standards.	1	2	3	4
b) Enforcing standards and discipling misconduct.	1	2	3	4
c) Providing programs of continuing education.	1	2	3	4
d) Seeking changes in legislation.	1	2	3	4

8. What are the main satisfactions you experience as a professional social worker?

9. What are the main frustrations you experience as a professional social worker?

Please use this space for any other comments you want to make (about your profession, this questionnaire, etc.)

Thank you very much for your co-operation in filling out this questionnaire. Please return it now, in the envelope proficed, to:

Prof. Charles Hanly, Project Director,
c/o Committee on the Healing Arts,
153 St. Clair Avenue West,
Toronto 7, Ontario.

At the same time, please mail separately the POSTAL CARD provided, so that we will know who have not returned questionnaires.

SURVEY FOR THE ONTARIO COMMITTEE ON THE HEALING ARTS: ADMINISTRATORS OF SOCIAL WORK AGENCIES AND DEPARTMENTS

INSTRUCTIONS: Where possible, please answer in the space provided; where not, please provide information in form convenient to you.

NOTE: The information that you provide will at no time be attributed individually to you or your agency or department. All data will be analyzed and reported in aggregate form.

Your name:_____ Your position: _____

1. Please indicate the number of your staff under the following headings:

Administrative: _____

Caseworkers: Full-time _____

Part-time _____

Group Workers: Full-time _____

Part-time _____

Clerical: _____

Community Organization Workers:

Full-time _____

Part-time _____

Case-aides, child welfare workers, etc.:

Full-time _____

Part-time _____

Please provide a breakdown or your full- and part-time social work staff by grade and educational qualification.

FOR EXAMPLE:

(Please use your own job classifications in responding)

	Full-time Social Work Staff			
	Caseworker I	Caseworker II	Caseworker III	Case-aide or Child Welfare Worker
S.W.				
S.W. or loma				
A.				
sing degree certificate				
er				

	Part-time Social Work Staff			
	Caseworker I	Caseworker II	Caseworker III	Case-aide or Child Welfare Worker
S.W.				
S.W. or loma				
sing degree certificate				
er				

How many budgeted social work positions do you have unfilled in each of the following categories?

1. Supervisor or senior social worker: _____

2. Social worker: _____

3. Case-aide, child welfare worker, etc.: _____

Given unlimited resources and the present demand for your services, how many additional social workers could you use in each of the following categories?

1. Supervisor or senior social worker: _____

2. Social worker: _____

3. Case-aide, child welfare worker, etc.: _____

Please provide the following information on the services rendered by your agency or department for (1) 1966; (2) 1961 (or the year closest to 1961 for which figures are available):

	1966	1961
a) cases open at the beginning of the year ..	____	____
b) cases opened during the year.....	____	____
c) cases terminated during the year	____	____
d) cases open at the end of the year	____	____

ANK YOU VERY MUCH FOR CO-OPERATING WITH THIS SURVEY.
EASE RETURN THE SURVEY FORM AND ALL ADDITIONAL DOCU-
NTS YOU HAVE PREPARED, IN THE ENVELOPE PROVIDED, TO:

Professor Charles Hanly,
Project Director,
Committee on the Healing Arts,
153 St. Clair Avenue West,
Toronto 7, Ontario.

SURVEY FOR THE ONTARIO COMMITTEE ON THE HEALING ARTS: ADMINISTRATORS OF SOCIAL WORK AGENCIES AND DEPARTMENTS

INSTRUCTIONS: Where possible, please answer in the space provided; where not, please provide information in form convenient to you.

NOTE: The information that you provide will at no time be attributed individually to you or your agency or department. All data will be analyzed and reported in aggregate form.

Your name:_____ Your position: _____

1. Please indicate the number of your staff under the following headings:

Administrative: _____

Caseworkers: Full-time _____

Part-time _____

Group Workers: Full-time _____

Part-time _____

Clerical: _____

Community Organization Workers:

Full-time _____

Part-time _____

Case-aides, child welfare workers, etc.:

Full-time _____

Part-time _____

Please provide a breakdown of your full- and part-time social work staff by grade and educational qualification.

FOR EXAMPLE: (Please use your own job classifications in responding)

	Full-time social work staff			
	Caseworker I	Caseworker II	Caseworker III	Case-aide or Child Welfare Worker
S.W.				
S.W. or ploma				
A.				
rsing degree certificate				
ner				

	Part-time social work staff			
	Caseworker I	Caseworker II	Caseworker III	Case-aide or Child Welfare Worker
S.W.				
S.W. or ploma				
A.				
rsing degree certificate				
ner				

Please provide a copy of your salary scale for social workers.

What is the average stay of social workers in your employ?

a) M.S.W.: _____ b) Other _____

5. Please provide data on the sources of referral to your agency or department in the year 1966 according to the following system of classification, or the equivalent in use in your agency or department:

HEALTH SERVICES: Total only

(e.g. District Public Health, General Hospital Clinics, V.O.N.) ..... _____

PSYCHIATRIC SERVICES:

Sub-totals

Mental Health Clinics ..... _____

Clarke Institute of Psychiatry ..... _____

Private Psychiatrists ..... _____

Ontario Hospitals ..... _____

Other ..... _____

Total ..... _____

SOCIAL SERVICES:

(e.g. Family Service Agencies, Dept. of Public Welfare, Family and Juvenile Court) ..... _____

COMMUNITY GROUPS:

Churches or Schools ..... _____

Doctors ..... _____

Lawyers ..... _____

Other ..... _____

Total ..... _____

INDIVIDUALS:

(e.g. Former clients, Relatives, Neighbours and friends, Volunteers) ..... _____

PUBLICITY:

(e.g. Radio, United Appeal, Telephone Book) ..... _____

6. How many cases in the year 1966 did you refer out to:

a) other community agencies _____
b) psychiatric services _____
c) other medical services _____

---

7. Please provide the following information on the services rendered by your agency or department for: (1) 1966; (2) 1961 (or the year closest to 1961 for which figures are available)

	1966	1961
a) cases open at the beginning of the year	____	____
b) cases opened during the year	____	____
c) cases terminated during the year	____	____
d) cases open at the end of the year	____	____

---

8. For the years 1966 and 1961 (or the year closest to 1961 for which the data are available) how many cases terminated during the year required:

	1966	1961
a) 0 - 3 in-person interviews	____	____
b) 4 - 10 in-person interviews	____	____
c) more than 10 in-person interviews ...	____	____

NOTE: Please adapt the categories in question 8 to your own statistical system where necessary.

---

9. Please provide figures on the primary focus of services rendered by your agency or department, according to the diagnostic classification that you use in your records (If you cannot make diagnostic records available in the form requested, please indicate so).
FOR EXAMPLE:

Primary focus of service:	Number of cases
1. Family and Individual Relationships:	
a) marital relationships	_____
b) parent-child relationship	_____
c)	_____
d)	_____
2. Environmental or Situational Conditions:	
a) financial difficulty	_____
b) physical illness or handicap	_____
c) mental illness	_____
d)	_____
e)	_____

NOTE: Please use the most specific information available. It is expected that the diagnostic classification in use will vary with the setting.

10. a) Do you charge fees to patients or clients for services rendered?

( ) Yes ( ) No

b) What proportion of your income comes from fees? _____%

---

11. a) Do you foresee a distinct role in your agency or department for case-aides or technicians with formal non-professional training in social welfare work? Why?

b) Do you employ such individuals at present?

( ) Yes ( ) No

c) If the answer to b) is YES, please describe the functions of such auxiliary personnel in your agency or department:

---

12. Please comment on the question of 'inappropriate referrals' as it affects your agency or department. Specifically,

a) how large is the problem and what are its consequences for your agency or department?
b) what are the main sources of, and reasons for 'inappropriate referrals'?

13. In the year 1966, what proportion of your clients or patients fell into the following categories?

a) widowed or separated: ..... _____%

b) unemployed or indigent: ..... _____%

c) chronically or incurably ill (with severe physical or mental disablement): ..... _____%

FOR ADMINISTRATORS IN HOSPITAL OR CLINIC SETTINGS ONLY:

14. a) Does a social worker from the social service department routinely see all patients or all patients in specified diagnostic groups at some time during the course of admission or treatment?

( ) Yes ( ) No

If the answer to 14 a) is YES,

b) Which groups are seen by the social worker?

15. a) Does the social service department have the authority to screen patient records and intervene in cases where social work is indicated?

( ) Yes ( ) No

If the answer to 15 a) is YES,

b) Please describe the arrangements for screening records and initiating social work where indicated:

If the answer to 15 a) is NO,

c) Please describe the procedures by which a patient is referred for social work:

16. What proportion of your patients are:

a) outpatients? _____%

b) inpatients? _____%

THANK YOU VERY MUCH FOR CO-OPERATING WITH THIS SURVEY. PLEASE RETURN THE SURVEY FORM AND ALL ADDITIONAL DOCUMENTS YOU HAVE PREPARED, IN THE ENVELOPE PROVIDED, TO:

Professor Charles Hanly,
Project Director,
Committee on the Healing Arts,
153 St. Clair Avenue West,
Toronto 7, Ontario.

SURVEY FOR THE ONTARIO COMMITTEE ON THE HEALING ARTS: DMINISTRATORS OF SOCIAL WORK AGENCIES AND DEPARTMENTS

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---

our name:_____ Your position: _____

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Administrative: _____

Caseworkers: Full-time _____

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Group Workers: Full-time _____

Part-time _____

Clerical: _____

Community Organization Workers:

Full-time _____

Part-time _____

Case-aides, child welfare workers, etc.:

Full-time _____

Part-time _____

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FOR EXAMPLE: (Please use your own job classifications in responding)

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	Caseworker I	Caseworker II	Caseworker III	Case-aide or Child Welfare Worker
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(e.g. District Public Health, General Hospital Clinics, V.O.N.) ..... _____

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Sub-totals

Mental Health Clinics ..... _____

Clarke Institute of Psychiatry ..... _____

Private Psychiatrists ..... _____

Ontario Hospitals ..... _____

Other ..... _____

Total ..... _____

SOCIAL SERVICES:

(e.g. Family Service Agencies, Dept. of Public Welfare, Family and Juvenile Court) ..... _____

COMMUNITY GROUPS:

Churches or Schools ..... _____

Doctors ..... _____

Lawyers ..... _____

Other ..... _____

Total ..... _____

INDIVIDUALS:

(e.g. Former clients, Relatives, Neighbours and friends, Volunteers) ..... _____

PUBLICITY:

(e.g. Radio, United Appeal, Telephone Book) ..... _____

6. How many cases in the year 1966 did you refer out to:

a) other community agencies _____
b) psychiatric services _____
c) other medical services _____

---

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c)	_____
d)	_____
2. Environmental or Situational Conditions:	
a) financial difficulty	_____
b) physical illness or handicap	_____
c) mental illness	_____
d)	_____
e)	_____

NOTE: Please use the most specific information available. It is expected that the diagnostic classification in use will vary with the setting.

10. a) Do you charge fees to patients or clients for services rendered?

( ) Yes ( ) No

b) What proportion of your income comes from fees? _____%

---

11. a) Do you foresee a distinct role in your agency or department for case-aides or technicians with formal non-professional training in social welfare work? Why?

b) Do you employ such individuals at present?

( ) Yes ( ) No

c) If the answer to b) is YES, please describe the functions of such auxiliary personnel in your agency or department:

---

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a) widowed or separated ..... _____%

b) unemployed or indigent ..... _____%

c) chronically or incurably ill (with severe physical or mental disablement) ..... _____%

FOR ADMINISTRATORS IN FAMILY OR CHILD AGENCIES ONLY:

14. a) Do you employ psychiatrists?

If the answer to 14 a) is YES,

b) Please indicate the number of psychiatrists employed:

Full-time _____ Part-time _____

If the answer to 14 a) is NO;

c) Please describe the arrangements for referral to and/or consultation with a psychiatrist where his service or advice is needed:

15. a) Do you employ other medical doctors?

If the answer to 15 a) is YES,

b) Please indicate the number of other medical doctors employed:

Full-time _____ Part-time _____

If the answer to 15 a) is NO,

c) Please describe the arrangements for referral to and/or consultation with a medical doctor where his service or advice is needed:

16. a) Do you employ psychologists?

If the answer to 16 a) is YES,

b) please indicate the number of psychologists employed:

Full-time _____ Part-time _____

If the answer to 16 a) is NO,

c) Please describe the arrangements for referral to and/or consultation with a psychologist where his service or advice is needed:

THANK YOU VERY MUCH FOR CO-OPERATING WITH THIS SURVEY. PLEASE RETURN THE SURVEY FORM AND ALL ADDITIONAL DOCUMENTS YOU HAVE PREPARED, IN THE ENVELOPE PROVIDED, TO:

Professor Charles Hanly,
Project Director,
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